NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Advanced Medical Home Manual 2.4.1
February 2022

Section I: Introduction

This Advanced Medical Home Manual 2.4 is a resource for Primary Care Providers (PCPs) as well as Clinically Integrated Networks (CINs) and Other Partners working with practices as they prepare for the go-live date of the Advanced Medical Home (AMH) program. The AMH program will go live with Medicaid Managed Care launch. This document updates and replaces the original Advanced Medical Home Manual published on December 12, 2018. It consolidates existing guidance into one document, including guidance released since the original Manual, but does not establish new policy or guidance.

The North Carolina Department of Health and Human Services ("the Department") developed the AMH model as the primary vehicle for care management as the state transitions to Medicaid Managed Care. High-quality primary care with the capacity to manage population health is foundational to the success of North Carolina's Medicaid Transformation, supporting the delivery of timely care in the appropriate setting to meet each Member's needs. The AMH model supports the Department's transformation vision by maintaining the strengths of North Carolina's legacy care management structure and promoting delivery of care management in the community.

On July 1, 2021, approximately 1.6 million Medicaid enrollees will move into Managed Care.[1] The Department's contract with Standard Plan Health Plans[2] establishes the AMH program as the vehicle for local care management integrated with primary care. The Standard Plan contract establishes the requirements on Health Plans associated with the AMH program and also establishes the mechanisms by which the Department will oversee the program.[3]

1 This manual applies to the AMH program under year 1 of Medicaid Managed Care in Standard Plans. For Care Management under BH/IDD Tailored Plans, please refer to the Department's Behavioral Health I/DD Tailored Plan website.

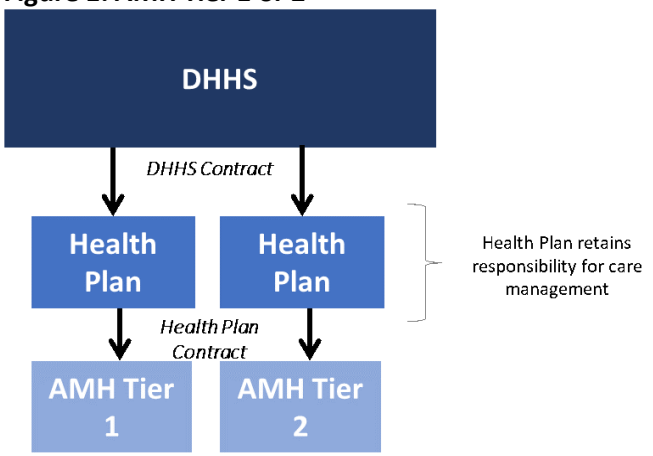
2 The information in this manual applies to practices participating in Medicaid Standard Plans. Practice requirements and other information for practices providing care management to Behavioral Health and Intellectual/Developmental Disability Tailored Plan members can be found in the Tailored Care Management Manual.

3 AMH requirements are found within the Standard Plan Scope of Services, Sections V.C.6.b and Attachment M.2.

As described in more detail in **Section II** of this manual, the AMH program contains three Tiers, as follows:

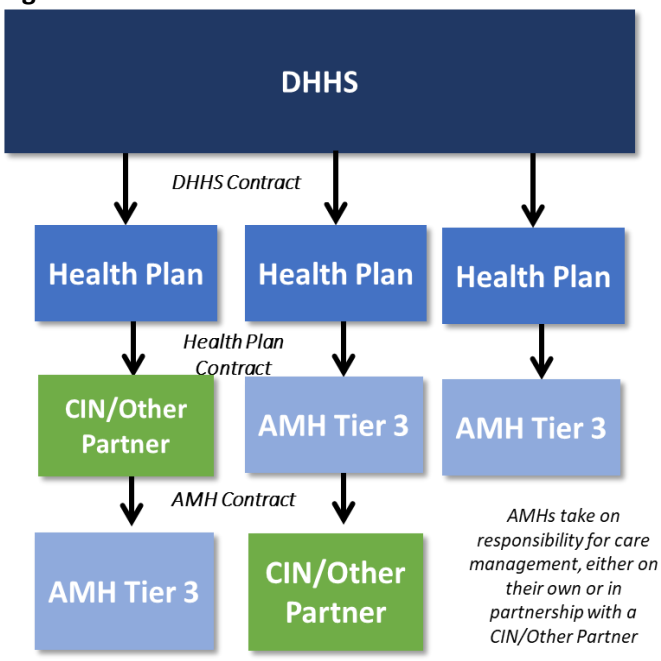
AMH Tier 1 or 2: Practices may choose to participate in the AMH program without practice-based responsibility for care management for high-need patients, or coordination of care across providers and settings for their patients. These practices, if they contract for services with multiple Health Plans, will interface and coordinate with those Health Plans' care management programs. AMH Tier 1 and 2 practices will receive medical home fees equivalent to Carolina ACCESS fees.

Figure 1: AMH Tier 1 or 2



AMH Tier 3: Practices opting into AMH Tier 3 take responsibility for care management and population health for their Medicaid managed care patients, allowing them to have a uniform platform of care management across the different Health Plans with which they contract. Clinically Integrated Networks (CINs) and Other Partners often play a role in organizing the work across Tier 3 practices and helping practices carry out the required responsibilities. Examples of functions typically assumed by the CIN or Other Partner are risk stratification, data aggregation and care management staffing. Health Plans must pay additional per-member-per-month (PMPM) fees to AMH Tier 3 practices, or the CIN/Other Partner on the practices' behalf, to reflect the care management function.

Figure 2: AMH Tier 3



Non-AMH Network PCP: Practices can choose to be in-network with one or more Health Plans but not participate in the AMH program, just as some practices did not participate in Carolina ACCESS prior to Medicaid Transformation. These practices will receive only fee-for-service payments for services without the additional per-member-per-month payments associated with the AMH program.

When Medicaid managed care launch occurs, primary care practices serving managed care Members will need to be contracted with Health Plans as AMH practices in order to receive AMH payments applicable by AMH Tier.

The AMH program is integrated with the Department's broader quality strategy under which Health Plans must meet population health targets. See **Section V** for the AMH quality measures.

The AMH model was designed to spur development of modernized, data-driven primary care that aligns with the Department's vision for advancing value-based payments over time. To promote care management that is well integrated with primary care, the AMH program requires Health Plans to work closely with AMH practices and regularly share data in specific ways. AMH Tier 3 practices must also report data back to Health Plans in a standardized format. These data flows are described in **Section V.**

The AMH model will evolve over time as practices gain data-driven capabilities and the market gains experience in managed care. The content of the manual applies to the first year of managed care implementation. DHHS reserves the right to update the manual or guidance at any time. Practices should regularly check DHHS' Medicaid bulletins and AMH website for additional guidance, updates and information.

Section II: AMH Practice Requirements

AMH Eligibility

Practices providing primary care as defined by the requirements for participation in the Carolina ACCESS program are eligible for the AMH program. Single and multispecialty groups led by allopathic and osteopathic physicians[4] in the following specialties, including certain subspecialties,[5] are eligible for participation:

- General Practice
- Family Medicine
- Internal Medicine
- OB/GYN
- Pediatrics
- Psychiatry and Neurology

Federally Qualified Health Centers, Local Health Departments, Public Health Clinics and Rural Health Clinics can also become AMHs.

All providers participating in an AMH practice must be enrolled in the state's Medicaid program. All practices must provide primary care services, although they may provide other services as well. There are no minimum panel size requirements, although practices serving only a small number of Medicaid enrollees may wish to consider how AMH participation can complement their practice transformation efforts with other payers to ensure sustainability. Practices do not need to have gained National Committee for Quality Assurance (NCQA) (or other external accreditor's) patient-centered medical home certification, or equivalent, in order to participate in the AMH program.

4 AMH providers can also include Physician Assistants and Advanced Practice Nursing Providers, such as Advanced Practice Midwives and Nurse Practitioners.

[5] For a full list of permitted subspecialties, please refer to NCTracks. The Carolina ACCESS program will remain in place as long as North Carolina Medicaid has enrollees receiving care under a fee-for-service model.

In early 2019, practices were asked to attest directly to the Department whether they will participate in AMH Tier 1, 2 or 3. If practices did not attest at that time, they were grandfathered in as follows:

- Carolina ACCESS I practices were recorded as AMH Tier 1s.
- Carolina ACCESS II practices were recorded as AMH Tier 2s.

No practices were automatically recorded as AMH Tier 3s; Tier 3 status always requires affirmative attestation. Health Plans have had the complete roster of AMH practices by tier since Health Plan awards were made, and they receive continuous feeds from NCTracks conveying any updates to attestations.

Practices that were not previously enrolled in Carolina ACCESS and wish to become AMH practices should refer to **Section VI** for details on AMH attestation. For information on how to check the tier status that is logged with DHHS, how DHHS will keep track of practices' tier status and how to change tier, if needed, see **Section VII.**

AMH Tier 1 and 2 Practice Requirements

AMH Tier 1 and 2 are designed to provide continuity with the current state prior to managed care launch. In AMH Tier 1 and 2, practices must continue to meet the same requirements that they met for Carolina ACCESS prior to Medicaid Transformation. These requirements are incorporated into the Department's contract with Health Plans, and Health Plans are required to include them in their contracts with AMH Tier 1 and 2 practices. Tier 1 and 2 practices will receive PMPM payments equivalent to what they received prior to managed care launch (see **Section IV** below).

These requirements are as follows:[6]

- Accept Members and be listed as a primary care provider in the Health Plan's Member-facing materials for the purpose of providing care to Members and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each Member, in accordance with Health Plan policies.
- Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provide direct patient care a minimum of thirty (30) office hours per week.
- Provide preventive services (see **Appendix A**).
- Maintain a unified patient medical record for each Member following the Health Plan's medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the Member's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider or Health Plan (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge.

[6] Standard Plan Contract Section VII. Attachment M.2; see also **Appendix A** of this manual.

- Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the Health Plan's network adequacy standards.
- Refer for a second opinion as requested by the Member, based on the Department's guidelines and Health Plan standards.
- Review and use Member utilization and cost reports provided by the Health Plan for the purpose of AMH-level utilization management, and advise the Health Plan of errors, omissions or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by the Health Plan for the purpose of participating in Health Plan or practice-based population health or care management activities.

For their Members attributed to AMH Tier 1 and 2 practices, Health Plans are responsible for care management of high-need Members, care coordination across settings, transitional care management and other bridging functions that go beyond the Carolina ACCESS requirements above. AMH Tier 1 and 2 practices may interface with multiple plan-based care management programs and staff if they contract with multiple Health Plans.

The only difference between AMH Tier 1 and 2 is each practice's status prior to managed care launch and whether the practice completed an attestation in NCTracks. AMH Tier 1 is for practices that were grandfathered in from Carolina ACCESS I and is no longer an option for other practices. AMH Tier 2 is for practices that were grandfathered in from Carolina ACCESS II. Practices that were previously in Carolina ACCESS I or were not in the Carolina ACCESS program can choose to enroll in AMH Tier 2 via NCTracks. AMH Tier 1 will be discontinued two years after managed care launch.

AMH Tier 3 Practice Requirements

AMH Tier 3 practices must meet all Tier 1-2 requirements above plus additional requirements that reflect capacity for data-driven care management and population health capabilities for their assigned populations.

The Tier 3 practice requirements are incorporated into the Department's contract with Health Plans. Health Plans must include these requirements in their contracts with AMH Tier 3 practices without changes and must monitor AMH practices' compliance with these same Tier 3 requirements. For additional information on monitoring and oversight of AMH practices, see **Section VII.** While Tier 3 standards contain significant overlaps with National Committee for Quality Assurance (NCQA) recognition (or other external primary care certification programs), such recognition is not required for AMH Tier 3.

Tier 3 practices must meet all of the following requirements.[7] Some or all of these requirements may be met on the practice's behalf by a CIN/Other Partner.

Requirement 1: Risk-stratify all empaneled members.

The expectation for Tier 3 AMHs is that they can combine risk information generated at the Health Plan level with their own clinical understanding of patients to produce a practice-wide view of risk and patient need, allowing targeting of care management to the right patients at the right time.

[7] Standard Plan Contract Section VII. Attachment M.2.

Table 1. Standard Terms and Conditions: Risk Stratification

Practices Must …	**Additional Information**[8]
1.1 *Ensure that assignment lists transmitted to the practice by the Health Plan are reconciled with the practice's panel list and are up to date in the clinical system of record.*	There is no set minimum interval at which practices should perform this review, but practices should develop a process to ensure that it is done when clinically appropriate. The clinical system of record is an electronic health record or equivalent.
1.2 *Use a consistent method to assign and adjust risk status for each assigned patient.*	Practices are not required to purchase a risk stratification tool; risk stratification by a CIN/Other Partner or application of clinical judgment to risk scores received from the Health Plan or another source suffice as strategies, as long as the practice's clinical team members have a shared understanding of the methodology.
1.3 *Use a consistent method to combine risk scoring information received from the Health Plan with clinical information to score and stratify the patient panel.*	
1.4 *To the greatest extent possible, ensure that the risk stratification method is consistent with the Department's program policy of identifying "priority populations"*[9] *for care management.*	Not all care team members need to be able to perform risk stratification, but all team members should follow stratification-based protocols (as appropriate) once a risk level has been assigned.
1.5 *Ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice level) and that the methodology is applied consistently.*	
1.6 *Define the process and frequency of risk score review and validation.*	There is no set required frequency, as long as there is a regular process.

[8] For more information on risk stratification, see AMH training webinar on risk stratification and Programmatic Guidance on Risk Stratification for AMH Tier 3 Practices.

[9] Priority populations, as defined in Section 6.a.iv.b.2 of the Standard Plan contract include individuals with LTSS needs; adults and children with Special Health Care Needs; individuals defined by the PHP as Rising Risk; individuals with high unmet health-related resource needs, defined at minimum to include members who are homeless, members experiencing or witnessing domestic violence or lack of personal safety, and members showing unmet health-related resource needs in three or more Healthy Opportunities domains on the Care Needs Screening; at risk children ages 0-5; high risk pregnant women; and other priority populations as determined by the PHP.

Requirement 2: Provide care management to high-needs patients.

Care management is foundational to the success of North Carolina's Medicaid system of care, supporting high-quality delivery of the right care in the right place and at the right time. Patients with high medical, behavioral or social needs should have access to a program of care management that includes the involvement of a multidisciplinary care team equipped to address the identified needs. The AMH Tier 3 requirements for high-need care management reflect the requirements that DHHS places on Health Plans when they perform care management directly.

Table 2. Standard Terms and Conditions: Care Management of High-Need Patients

Practices Must …	**Additional Information**
2.1 *Use risk stratification methods to identify patients who may benefit from care management.*	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management. Care management designations need not precisely mirror risk stratification levels.
2.2 *Perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:* • *Patient's immediate care needs and current services;* • *Other state or local services currently used;* • *Physical health conditions, including dental;* • *Current and past behavioral and mental health and substance use status and/or disorders;* • *Physical, intellectual developmental disabilities;* • *Medications – prescribed and taken;* • *Priority domains of social determinants of health (housing, food, transportation and interpersonal safety); and* • *Available informal, caregiver or social supports, including peer supports.*	In preparation for the assessment, care team members may consolidate information from a variety of sources and must review the Initial Care Needs Screening performed by the Health Plan (if available). The clinician performing the assessment should confirm the information with the patient. After its completion, the Comprehensive Assessment should be reviewed by the care team members. The assessment should go beyond a review of diagnoses listed in the patient's claims history and include a discussion of current symptoms and needs, including those that may not have been documented previously. The section of the assessment reviewing behavioral and mental health may include brief screening tools such as the PHQ-2 or GAD-7 scale, but these are not required. The patient may be referred for formal diagnostic evaluation. The practice or CIN/Other Partners administering the Comprehensive Assessment should develop a protocol for situations when a patient discloses information during the

Practices Must …	Additional Information
	Assessment indicating an immediate risk to self or others. The review of medications should include a medication reconciliation on the first Comprehensive Assessment, as well as on subsequent Assessments if the patient has not had a recent medication reconciliation related to a care transition or for another reason. The medication reconciliation should be performed by an individual with appropriate clinical training.
2.3 *Have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.*	Care managers must be assigned to the practice but need not be physically embedded at the practice location.
2.4 *For each high-need patient, assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.*	A patient may decline to engage in care management, but the practice or CIN/Other Partner should still assign a care manager and review utilization and other available data in order to inform interactions between the patient and his/her clinician during routine visits.

Requirement 3: Develop a care plan for all patients receiving care management.

A written care plan helps the care management team document the patient's needs and goals, identify appropriate services, and track progress against goals over time. The care plan also promotes alignment across all members of a patient's care team to ensure the services a patient receives are coordinated and working together to advance progress toward the patient's health goals.

Table 3. Standard Terms and Conditions: Developing a Care Plan for All Patients Receiving Care Management

Practices Must …	Additional Information
3.1 *Develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan. Incorporate*	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management, but care management

Practices Must …	**Additional Information**
findings from the Health Plan Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.	designations need not precisely mirror risk stratification levels.
3.2 *Include, at a minimum, the following elements in the Care Plan:* • *Measurable patient (or patient and caregiver) goals;* • *Medical needs, including any behavioral health and dental needs;* • *Interventions, including medication management and adherence;* • *Intended outcomes; and* • *Social, educational and other services needed by the patient.*	Practices should take an individualized, person-centered and collaborative approach to Care Plan development and should be able to describe how their Care Plan development approach demonstrates these attributes.
3.3 *Have a process to document and store each Care Plan in the clinical system of record.*	The clinical system of record may be the electronic health record.
3.4 *Periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.*	There is no set minimum interval at which practices should perform this review, but practices should develop a process to ensure that it is done when clinically appropriate.
3.5 *Have a process to update each Care Plan as Member needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.*	As Member needs change, the AMH should update the care plan to reflect these changes.
3.6 *Track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admission, discharge and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time.*	While not required, practices are also encouraged to develop systems to ingest ADT information into their electronic health records or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s).
3.7 *Implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (below) within a several-day period to address outpatient needs or prevent future problems for high-risk patients who have been*	Practices (directly or via CIN/Other Partners) are not required to respond to all ADT alerts in these categories, but they are required to have a process in place to determine which notifications merit a response and to ensure

Practices Must …	Additional Information
discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge): • *Real-time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions – for example, arranging rapid follow-up after an ED visit to avoid an admission.* • *Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital.*	that the response occurs. For example, such a process could designate certain ED visits as meriting follow-up based on the concerning nature of the patient's complaint (suggesting the patient may require further medical intervention) or the timing of the ED visit during regular clinic hours (suggesting that the practice should reach out to the patient to understand why he or she was not seen at the primary care site). The process should be specific enough – with regard to the designation of ADT alerts as requiring or not requiring follow-up, the interval within which follow-up should occur, and the documentation that follow-up took place – to enable an external observer to easily determine whether the process is being followed.

Requirement 4: Provide short-term, transitional care management, along with medication management, to all empaneled patients who have an ED visit or hospital admission/discharge/transfer and who are at high risk of readmission and other poor outcomes.

Patients who are transitioning from one care setting to another, such as from the hospital back to the community, can benefit from short-term support to prevent unplanned or unnecessary readmissions or other adverse outcomes. Care management teams can support these patients by facilitating clinical handoffs, conducting medication reconciliation and ensuring they receive appropriate follow-up care.

Table 4. Standard Terms and Conditions: Transitional Care Management

Practices Must …	Additional Information
4.1 *Have a methodology or system for identifying patients in transition who are at risk of readmission and other poor outcomes that considers all of the following:* • *Frequency, duration and acuity of inpatient, Skilled Nursing Facility (SNF) and Long Term Services and Supports (LTSS) admissions or ED visits;* • *Discharges from inpatient behavioral health services, facility-based crisis services, non-*	Practices or their CIN/Other Partner may use whichever methodology and information they see fit to identify patients in need of transitional care management.

Practices Must …	Additional Information
hospital medical detoxification, or a medically supervised or alcohol/drug abuse treatment center; • *Neonatal intensive care unit (NICU) discharges; and* • *Clinical complexity, severity of condition, medications and risk score.*	
4.2 *For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credential of RN or LCSW.*	A patient may decline to engage in care management, but the practice should still assign a care manager and review utilization and other available data in order to inform interactions between the patient and his/her clinician during the transition period.
4.3 *Include the following elements in transitional care management:* • *Ensuring that a care manager is assigned to manage the transition;* • *Facilitating clinical handoffs;* • *Obtaining a copy of the discharge plan/summary;* • *Conducting medication reconciliation;* • *Following up by the assigned care manager rapidly following discharge;* • *Ensuring that a follow-up outpatient, home visit or face-to-face encounter occurs; and* • *Developing a protocol for determining the appropriate timing and format of such outreach.*	The practice must have a process for determining a clinically appropriate follow-up interval for each patient that is specific enough – with regard to the interval within which follow-up should occur and the documentation that follow-up took place – to enable an external observer to easily determine whether the process is being followed.

Requirement 5: Be able to receive claims data feeds and meet state-designated security standards for claims storage and use.

To provide appropriate care management services to empaneled patients and work toward improved care outcomes, Tier 3 practices will need to have timely access to relevant, patient-level data. To meet this requirement, Tier 3 practices (or their CIN/Other Partners) must receive claims data feeds and meet

state-designated security standards for their storage and use.[10] See **Section V** for additional information on the standardized data flows that will support the AMH program.

Future Evolution of AMH Practice Requirements

The Department views the AMH program as the vehicle for promoting data-enabled primary care that is able to assume responsibility for the whole-person health of populations. This transition takes time, and the initial AMH Tier 3 set of requirements is a starting point that intentionally prioritizes the use of data for the management of population needs. The Department expects to evolve the AMH program requirements after 1-2 years of experience in managed care.

One particularly fast-moving area both nationally and in North Carolina is primary care's increasing role in addressing healthy opportunities, or social needs that impact individuals' health. In the planning for Medicaid Transformation, North Carolina is building capacity for the Medicaid delivery system to better integrate health care with addressing social needs, including preparation for North Carolina's Healthy Opportunities initiative and the deployment of the NCCARE360 platform, a statewide, coordinated care network to electronically connect those with identified needs with community resources. In year 1 of managed care, AMH practices are encouraged (but not formally required) to screen patients for unmet resource needs and use the information from the screening to refer patients to community-based resources to address their unmet needs. The Department is considering adding more explicit healthy opportunities requirements after the first year of managed care experience.

[10] Standard Plan Contract III.E.5.

Section III: AMH Payment Model

The AMH payment model is designed to provide a smooth transition from the payment model in place prior to Medicaid Transformation while also introducing payment linked to performance on the AMH measure set (see **Section IV**). In addition to Medicaid clinical services fees (fee for service), the Health Plan contract requires Health Plans to pay AMH practices three types of payments. These payments are described in Table 5 and the accompanying text.

Summary of Payment Model by Tier

Table 5. Summary of Payment Model by Tier

AMH Tier	Medical Home Fees[11]	Care Management Fees	Performance Incentive Payments
Tier 1	$2.50 (most Members) or $5.00 (Members in the aged, Blind, and disabled [ABD] eligibility group)	None	None required, but Health Plans are encouraged to begin offering performance incentive payments based on AMH measures
Tier 2	$2.50 (most Members) or $5.00 (Members in the ABD eligibility group)	None	
Tier 3	$2.50 (most Members) or $5.00 (Members in the ABD eligibility group)	Negotiated between practices (or CINs/Other Partners on behalf of practices) and Health Plan	Health Plans must pay performance incentive payments to practices if practices meet performance thresholds on AMH measures

- **Medical Home Fees:** Non-visit-based payments to AMH practices, providing stable funding for care coordination support and quality improvement at the practice level, as defined by the AMH Tier 1 and 2 requirements set out in **Section II** above.[12] All AMH practices will receive medical home fees for all their attributed patients. PMPM amounts for the medical home fees are set by the Department and continue the Carolina ACCESS fees in place prior to managed care launch. Medical practices in AMH Tiers 1, 2, and 3 will receive $2.50 PMPM for most Members and $5.00 PMPM for Members in the aged, blind, and disabled Medicaid eligibility group.[13]

[11] During the COVID-19 Public Health Emergency (PHE), which continues at the time of publication of this manual, Carolina ACCESS fees are temporarily increased. These changes will carry into Managed Care if the PHE is still in effect when Managed Care launches.

[12] Standard Plan contract, p. 26.

[13] During the PHE, which continues at the time of publication of this manual, Carolina ACCESS fees are temporarily increased. These changes will carry into Managed Care if the PHE is still in effect when Managed Care launches.

- **Care Management Fees:** Non-visit-based payments to AMH Tier 3 practices (or CINs/Other Partners on their behalf), providing stable funding for the assumption of primary responsibility for care management and population health activities at the practice level.[14] Care management fees that Health Plans pay to AMHs are set through negotiations between Health Plans and Tier 3 practices (or CINs/Other Partners acting on their behalf). The Department is not imposing a rate floor on these care management fees. However, in 2019 the Department issued guidance on the capitation rate assumptions that explains the Department's assumed costs for delivering care management. This guidance remains in effect for the first year of managed care. Health Plans must pay the full negotiated care management fee amount. Payment of Tier 3 practices' care management fees, or any portion of their care management fees, may not be conditioned on performance or otherwise put at risk.[15]

- **Performance Incentive Payments:** Payments additional to fee for service, care management fees and medical home fees that are contingent upon practices' reporting of and/or performance against the AMH Performance Metrics.[16] Health Plans are required to offer Performance Incentive Payment opportunities to Tier 3 practices and are encouraged to offer them to practices in Tiers 1 and 2. While performance thresholds and payment rates are set by Health Plans, all performance incentive payments must be based exclusively on the AMH measure set and not on measures outside the set.[17] See **Section IV** for the AMH Measure List. Due to differences in the Health Plan contract year and the quality measurement reporting time period, the performance period for AMH quality measurement will start six months after managed care launch (see **Section IV** below).

AMH Payment Model and Advanced Value-Based Payment Models

The Department recognizes that some practices and CINs/Other Partners may be interested in moving beyond the current AMH Tier 3 model toward more advanced value-based contracts that include increased accountability for total cost of care and/or shift payments to practices to a primary care capitated model (HCP-LAN level 3A or above). The Department strongly encourages these developments, which align with the Department's Value-Based Payment Strategy. Health Plans and practices that wish to enter into payment arrangements beyond Tier 3 in the HCP-LAN taxonomy may elect to do so at any time, with prior approval of the Department.

Appendix D. Provides details on participation in the Integrated Care for Kids (InCK) Model for AMHs serving InCK enrolled members whose Medicaid administrative county is Alamance, Durham, Granville, Orange or Vance County. There will be a voluntary Alternative Payment Model (APM) available to AMH practices serving InCK enrolled members beginning in July 2022. Additional guidance Is forthcoming.

Appendix H. provides Health Opportunities Fee Schedule. Awarded Healthy Opportunities network leads are Access East, Inc., Community Care of the Lower Cape Fear, and Dogwood Health Trust. See **Appendix G.** for the map of counties covered under each respective lead.

---

[14] PHP contract, p. 21.

[15] "Notice of Advanced Medical Home Policy Changes Memo" (11/20/2020), https://medicaid.ncdhhs.gov/blog/2020/11/20/notice-advanced-medical-home-amh-policy-changes-memo. [16] PHP contract, p. 27.

[17] "Notice of Advanced Medical Home Policy Changes Memo" (11/20/2020), ibid.

Section IV: Quality

To ensure delivery of high-quality care under the managed care delivery system, the Department has developed a Medicaid managed care Quality Strategy and identified a set of quality metrics that it will use to assess Health Plans' performance across their entire populations. The Department has identified a subset of these measures for Health Plans to use to monitor AMH performance and calculate AMH performance incentive payments.

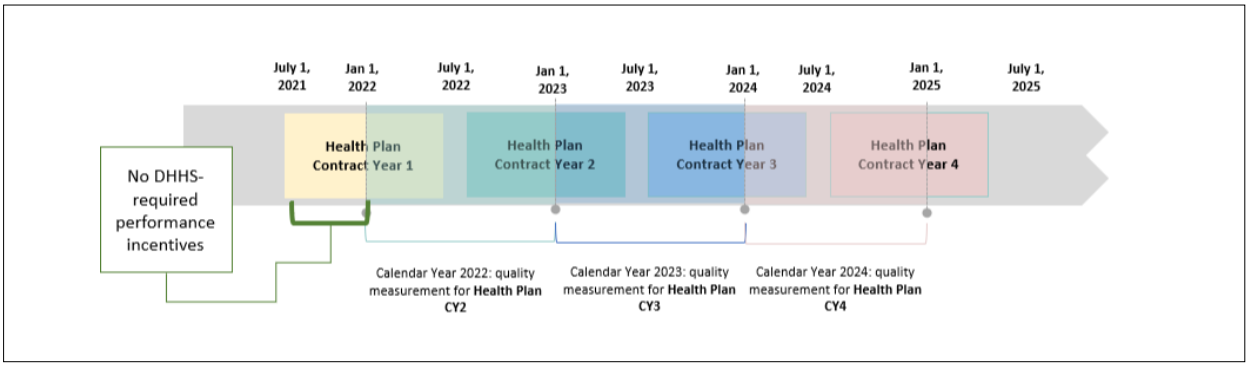
Figure 3. AMH Quality Metrics for Calendar Year 2022

Calendar Year 2022 AMH Measure Set
• Child and Adolescent Well-Care Visit • Childhood Immunization Status (Combination 10) • Immunization for Adolescents (Combination 2) • Screening for Depression and Follow-up Plan • Well-Child Visits in the First 30 Months of Life[18] • Cervical Cancer Screening • Chlamydia Screening in Women • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) • Controlling High Blood Pressure • Plan All-Cause Readmission – Observed to Expected Ratio

All quality measures that each Health Plan incorporates into its contracts with AMH practices (all Tiers) must be taken from this measure set, although Health Plans are not required to use all AMH measures. For the Year 1 AMH measure set, the Department prioritized measures that can be calculated using claims data (i.e., practices will not be required to submit any additional information to Health Plans for the majority of these measures). If Health Plans and AMHs choose to use measures for which hybrid reporting is appropriate (e.g., Comprehensive Diabetes Care: HbA1c Poor Control), the Department encourages Health Plans to use consistent reporting approaches that will minimize burden on AMH practices.

Measurement for all Department-required quality incentive programs, including AMH, will be aligned with calendar years. Therefore, the first quality performance period for AMH will not begin until approximately six months after the launch of managed care. See Figure 4.

Figure 4. AMH Performance Incentive Payment Timeline



[18] This measure replaces the now retired "Well-Child Visits in the First 15 Months of Life" measure.

After managed care launch, the Department will work with the AMH Technical Advisory Group (TAG) to collect and align reporting approaches and to align to the greatest extent possible the feedback reports that Health Plans will share back with AMH practices to show their performance on the measure set.

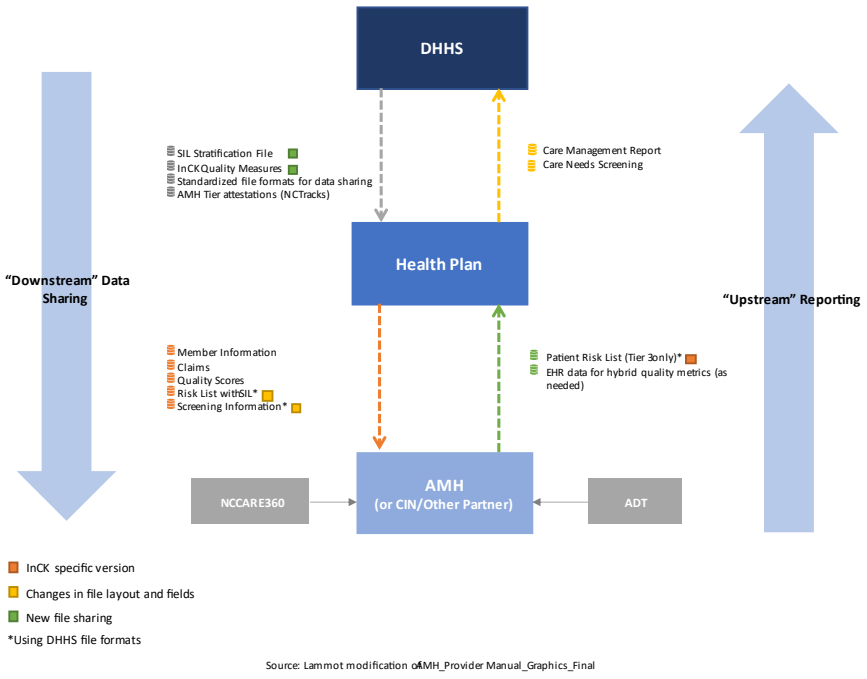
Section V: Data Exchange between Health Plans and AMH Practices

A key component of the Department's vision for AMH is that practices will be equipped with data to support their ability to manage the health of their populations. To achieve this vision and promote a population approach at the level of each practice, the Department has set requirements for "downstream" AMH data sharing within the Health Plan contract and has rolled out standards for certain critical data flows. At the same time, the Department has standardized "upstream" data reporting between AMH practices, Health Plans and the Department to mitigate administrative burden and improve the quality of data flowing to Health Plans and the Department for oversight purposes.

Figure 5. AMH Program Data Flows

"Downstream" Data Flows from Health Plans to AMHs and CINs/Other Partners

To support AMH practices in carrying out care management and related functions for their population, the Department requires Health Plans to share multiple data types with their contracted AMH practices (whether directly or through a designated CIN/Other Partner).[19] In the ramp-up to managed care launch, the Department has been working intensively with Health Plans and AMH practices/CINs or Other Partners to standardize file formats for the most critical data for care management, as described below.



[19] For more information on data that AMH practices will receive, refer to the PHP contract, "Advanced Medical Home Data and Information Sharing" Section 6.b.IV.c. See also the Department's 2018 white paper "Data Strategy to Support the Advanced Medical Home Program in North Carolina."

Health Plans are required to share the following data types with AMH practices in their networks:

- **Member Assignment Files (all AMH Tiers):** Health Plans are required to deliver timely, accurate information to AMH practices about the members that have been assigned to them. The way that Health Plans are required to share this data differs by AMH Tier.
    - **For Tier 1 and 2 practices,** Health Plans must share, in a format of their choosing:
        - Point-in-time assignment, on at least a monthly basis;
        - Projected assignment information for the following month (to the extent the information is available);
        - Information about newly assigned Members to the Health Plan, within seven (7) business days of enrollment (more rapid notification may be required for assignment of newborns);
        - Notifications of any ad hoc changes in assignment as they occur, within seven (7) business days of each change.
    - **For Tier 3 practices or CINs/Other Partners acting on their behalf,** Health Plans must share member assignment files and pharmacy lock-in data using specific file layouts and transmission protocols established by the Department. The Department's file layout uses the 834 EDI Enrollment standard file format as the baseline. Health Plans are to complete testing with partner AMH Tier 3 practices/CINs/Other Partners prior to Managed Care launch.[20]

- **Claims and encounter data (AMH Tier 3 only):** Health Plans must share timely claims and encounter data with Tier 3 practices using a file format as specified on the AMH Data Specification Guidance website. Health Plans are required to complete testing with partner AMH Tier 3 practices/CINs/Other Partners prior to managed care launch.[21]

- **Health Plan risk scoring and risk stratification results (all AMH Tiers):** Health Plans must share results of their risk scoring with all AMH practices, including (where possible and relevant) Member-level information about cost and utilization. For Tier 3 only, the Department is standardizing this process by providing Health Plans with a Patient Risk List Template that Health Plans will use to share risk information with Tier 3 AMH practices (or CINs/Other Partners on their behalf), pre-populated with assigned Members and their respective risk profiles, on a monthly basis. As described below (see "'Upstream' Reporting from AMHs to Health Plans"), this report links to practices' "upstream" reporting to the Health Plan on the care management encounters that actually took place for the Members, via the Patient Risk List.

- **Initial Care Needs Screening results (all AMH Tiers and non-AMH PCPs):** Health Plans are required to conduct an "Initial Care Needs Screening" to assess Member health and unmet resource need within 90 days of Members' enrollment. Health Plans are required to share the results of the Initial Care Needs Screening with PCPs within seven (7) days of screening or within seven days of assignment to a new PCP, whichever is earlier.

[20] The full specifications and protocol are available on the DHHS website; see "Requirements for Sharing Beneficiary Assignment and Pharmacy Lock-in Data to Support AMHs, CMARC and CMHRP."
[21] For more information on claims and encounter data sharing, see "Requirements for Sharing Encounters and Historical Claim Data to Support AMHs, CMARC and CMHRP" on the AMH Data Specification Guidance website.

- **Quality measure performance information (all AMH Tiers):** As noted in **Section III,** Health Plans will use a set of quality metrics to assess AMH performance and calculate performance-based payments. Health Plans will share with AMHs information on the quality measures included in AMH practices' contracts. Health Plans will also be required to share total cost of care information with AMH practices.

"Upstream" Reporting from AMHs to Health Plans

AMH practices will report information back to Health Plans as follows:

- **Care Management Reporting (Tier 3 only):** Health Plans are responsible for reporting to the Department the care management activities delivered to their entire populations. The vehicle for this report is called the Care Management Report. The Care Management Report includes member-level care management encounter reporting that spans care management provided by the Health Plan itself, Local Health Departments and AMHs. From the Department's perspective, the purpose of the Care Management Report is to monitor the total level and types of activity in the market to inform future policy and rate development.

  To ensure that Health Plans have complete information for the Care Management Report, the Department has standardized how Tier 3 AMHs are required to report care management encounter information to each Health Plan for inclusion in the Care Management Report. After hearing requests from AMH Tier 3s that care management reporting be streamlined across Health Plans to the greatest extent possible, the Department developed a standardized tool called the **Patient Risk List** for risk reporting, which is available on the AMH Data Specification Guidance website. This template is both the vehicle for AMH Tier 3 practices (or their CINs/Other Partners) to receive member-level risk information and to transmit care management encounter data to the Health Plan. AMH Tier 1 and 2 practices are not required to complete the Patient Risk List Template.

  The Patient Risk List Template includes, for each assigned patient:

  - The AMH risk score;
  - The number of care management interactions;
  - The number of face to face care management encounters;
  - The date on which the comprehensive assessment was completed;
  - The date on which the care plan was created (when applicable);
  - The date on which the care plan was updated (when applicable); and
  - The date on which the care plan was closed (when applicable).

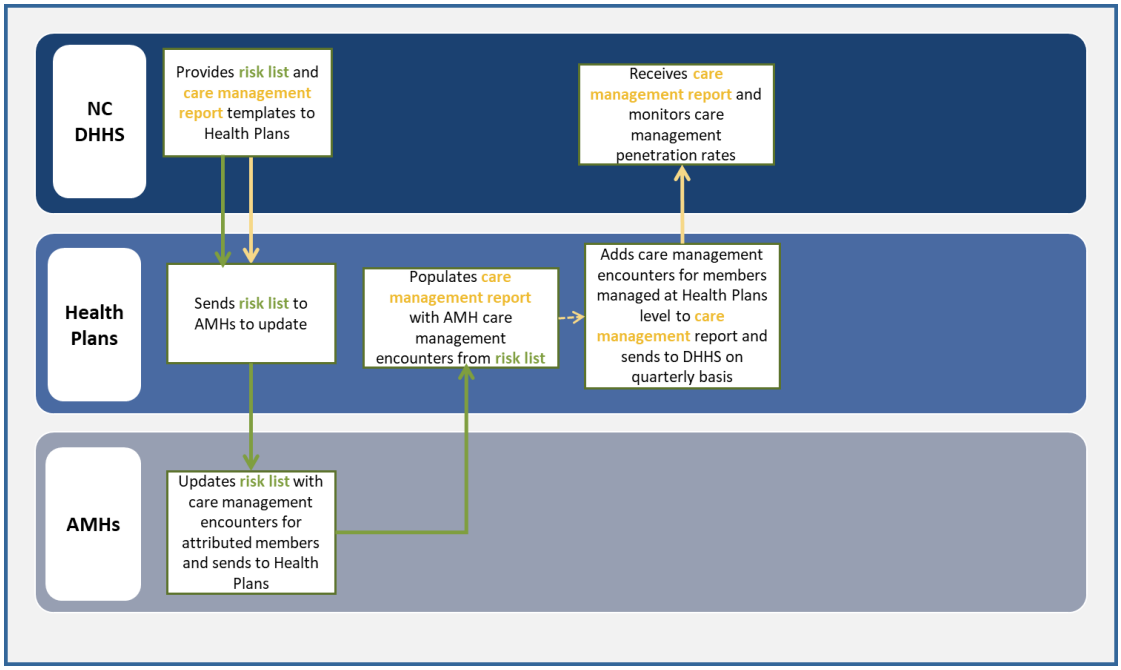
  For the purposes of the Patient Risk List, Tier 3 AMHs (or their CINs/Other Partners) should report all levels of care management, ranging from high intensity (e.g., Care Plan development and frequent face-to-face encounters) to low intensity (e.g., infrequent, telephonic contact). For the purposes of care management reporting, the Department considers the following to be care management encounters:

- In-person (including virtual) visit with care manager; could include delivery of Comprehensive Assessment, development of Care Plan or other discussion of patient's health-related needs.
- Phone call or active email/text exchange between member of care team and Member (must include active participation by both parties; unreturned emails/text messages do NOT count).
- Phone call or active email/text exchange between member of care team and Member discussing Care Plan or other health-related needs.

The following should **not** be reported as care management encounters in the risk reporting template:

- Care Management for At Risk Children (CMARC) and Care Management for High Risk Pregnancy (CMHRP) encounters.
- Care manager leaves a voicemail with Member or sends unreturned email/text message.
- Health Plan/care manager sends mailer to Member.
- Phone calls between Member and practice front desk staff for scheduling purposes.
- Scheduled in-person visit to which the Member fails to show up.

Figure 6. Patient Risk Reporting and Care Management Report Flow



- ***"Upstream" quality reporting* (all AMH Tiers):** Separately from the Patient Risk List, Health Plans may require AMH practices to share electronic health record (EHR) data for the purposes of quality measurement if the Health Plans select AMH measures with hybrid claims/clinical specifications.
- ***Additional "upstream" reporting:*** Health Plans may request that AMHs report additional data; however, any AMH reporting requirements not listed in this manual are unique to the Health Plans and not required by the Department. AMH practices may negotiate which additional data

elements to share and how frequently they will share them when contracting with Health Plans. DHHS does not require AMH Tier 3 practices to share Comprehensive Assessments or Care Plans back with Health Plans.

ADT Data Flows and NCCARE360

In addition to receiving data from Health Plans, Tier 3 AMH practices are required to access admission, discharge and transfer (ADT) data; while Tier 1 and 2 practices are not required to access ADT data, they are strongly encouraged to do so. AMHs will also need timely access to certain clinical information for care oversight and management, including information about members' test results, lab values and immunizations. Practices have several options for how and where to access clinical data, such as clinical data from affiliated health systems' EHR software, or NC HealthConnex. Practices may also work through their CINs/Other Partners to obtain this data.

AMHs are encouraged to access NCCARE360 for information regarding available community resources to address members' health-related resource needs. NCCARE360 is the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. As of June 2020, NCCARE360 is available in every county in North Carolina. Practices should refer to the NCCARE360 website for information about how to gain access.

Section VI: AMH Attestation and Certification

To participate in the AMH program, practices must be certified as AMHs by the Department. AMH certification is a noncompetitive process whereby practices that complete a series of steps and attest to AMH Tier-specific practice requirements are certified by the Department as eligible for participating in the corresponding Tier. After the Department certifies an AMH practice and notifies it of its Tier status, the practice can then contract with Health Plans in its region at the Tier for which the practice is certified. The Tier for which a practice receives Departmental certification represents the highest Tier level at which that practice is able to contract with a Health Plan. Practices may choose to contract at different Tiers with each Health Plan, though they may not exceed their highest Tier certification with any Health Plan. Certification does not obligate practices to participate in the AMH program, and a certified AMH may choose not to contract as an AMH practice.

Practices' path to entry into the AMH program will depend on their level of participation in the Carolina ACCESS (CA) program. CAI and CAII providers will be grandfathered into AMH Tiers 1 and 2, respectively. CAI providers that wish to join a higher Tier may attest into Tier 2 or 3 in NCTracks. CAII providers that wish to join AMH Tier 3 may likewise attest into Tier 3 in NCTracks. Only current CAI practices will be permitted to join AMH Tier 1; therefore, practices grandfathered into AMH Tier 2 will not be permitted to lower their status to AMH Tier 1.

Practices that are not currently participating in Carolina ACCESS at any level, including newly formed practices and practices that are new to North Carolina, must join Carolina ACCESS in order to participate in the AMH program. Carolina ACCESS participation can be added to a provider record during initial enrollment or via a Manage Change Request (MCR). Once the Department determines the practice meets Carolina ACCESS requirements and approves provider record updates, the provider will

automatically be assigned an AMH Tier 2 status. Practices will then have the opportunity to enter AMH Tier 3 by attesting to AMH Tier 3 practice requirements in NCTracks. As previously noted, only current CAI providers will be allowed to join AMH Tier 1. Therefore, new Carolina ACCESS practices joining AMH Tier 2 will not be permitted to lower their status to AMH Tier 1.

For more information on AMH Tier attestation and joining Carolina ACCESS to participate in the AMH program, see the AMH Tier Attestation Overview on NCTracks.

Checking or Changing AMH Status

Practices may confirm or change their AMH status on the NCTracks site. If a practice certified as an AMH Tier 3 determines that it needs additional time to meet Tier 3 requirements, it may change its Tier status without penalty. To change status, the Tier 3 practice should enter its NP/Atypical ID and Service Location in NCTracks and select "Downgrade to AMH Tier Level 2." Similarly, if a practice certified for a lower AMH determines it is ready to meet Tier 3 requirements, it may attest into Tier 3 on NCTracks to request Departmental certification as a Tier 3 practice. There is no limit to how often a practice can upgrade or downgrade its AMH Tier. However, because Tier changes will be effective on the first day of the following month, subsequent changes must occur after the practice's most recent Tier change goes into effect. See Protocol for Changing Advanced Medical Home Tier Status for additional information.

Section VII: Contracting and Oversight

AMH Contracting

For AMH Tiers 1 and 2, Health Plans are required to enter into contracts with practices that meet the requirements described in **Section II**. For AMH Tiers 1 and 2, Health Plans must accept the certification "as is" without the ability to review during the initial contracting process. Health Plans will be required to include language that reflects the Tier 1 and 2 requirements (**Appendix A**).

For AMH Tier 3, Health Plans will be required to enter into contracts with those practices that meet the requirements described in **Section II**. Health Plans may assess the capabilities of Tier 3-certified practices as part of the initial contracting process and prior to managed care launch. Health Plans are required to include language that reflects both the Tier 1 and 2 requirements (**Appendix A**) and the Tier 3-specific requirements (**Appendix B**). Activities by Health Plans may include conducting an onsite review, telephone consultation, documentation review or other virtual/offsite reviews. Based on the extent to which AMH Tier 3 functions are undertaken by a CIN/Other Partner, the Health Plan may perform an evaluation of the CIN/Other Partner instead of or in addition to the AMH practice. Health Plans may not condition year 1 AMH Tier 3 contracts on audits/monitoring activities that go beyond what is necessary for practices to meet Tier 3 requirements, including requirements imposed as part of NCQA pre-delegation auditing. AMHs and Health Plans may, however, by mutual agreement prepare for NCQA pre-delegation or otherwise build care management capacity during year 1.

The Department will review and approve all Health Plan/AMH practice contract templates prior to use to ensure that standard contract terms are incorporated. Contracts must:

- Be mutually agreed upon;
- Assign responsibilities (details of activities performed vs. retained) and specify responsibilities;

- Assign responsibilities that contain all required elements included in Appendix A (for all AMH practices) and Appendix B (for Tier 3 AMH practices);
- Specify reporting standards and performance monitoring (in alignment with the Department's standards);
- Specify consequences for underperformance, including appeals rights;
- Include data sharing and provisions for privacy/security, in alignment with the Department's data sharing policies.

Health Plans must share with each AMH Tier 3 practice a description of the oversight process it will use to monitor practices' performance against specific AMH requirements, including the processes it will use to monitor the CIN/Other Partner with which the practice is affiliated. In the event of a compliance action against a CIN/Other Partner, the Health Plan will provide notice to each AMH Tier 3 practice affiliated with that CIN/Other Partner within 60 days.

AMH Oversight and "Downgrades"

After launch, if an AMH practice is not able to perform the activities associated with its AMH tier, the Health Plan may "downgrade" the practice, or move a practice out of the AMH program altogether. For AMH Tier 3, the Department will permit Health Plans to stop paying the AMH Tier 3 payment components and lower the Tier status of the AMH practice if the practice is unable to perform Tier 3 functions.[22] Health Plans must have a defined process for "downgrade" actions that includes at least thirty (30) days for remediation of noncompliance. In the event of a compliance action against a CIN/Other Partner, the Health Plan must provide notice to each AMH Tier 3 associated with that CIN/Other Partner within sixty (60) days.[23]

AMH practices have the right to appeal any such downgrades to the Health Plan by going through the Health Plan's regular appeals process.[24] There will be no direct route of appeal to the Department.

The Department will monitor Health Plans' downgrade decisions as part of its overall monitoring of Health Plan activities and may consider Health Plans' pattern of downgrading in its ongoing compliance activities and in subsequent monitoring decisions.

Section VIII: Practice Supports and Other Resources

NC Medicaid, in partnership with NC Area Health Education Centers (AHEC), is providing education, engagement, outreach and practice-level technical assistance aligned with the AMH program. As of January 2021, AHEC coaches have been working with individual practices to accelerate the adoption of Tier 3 standards and facilitate transition to AMH Tier 3, starting with use of a standardized assessment tool. Coaching will be available to primary care practices that are in network with at least one Standard Plan. For more information on AHEC practice supports, visit https://www.ncahec.net/practice-support/advanced-medical-home/.

The Department also publishes AMH policy papers, programmatic guidance and FAQs for AMH providers on its AMH webpage. AMHs should contact the Health Plans with which they have contracted for

[22] Standard Plan Scope of Services, Section V.C.6.b.iv.d.4.
[23] See "Advanced Medical Home Policy Changes," Nov. 16, 2020.
[24] Standard Plan Contract, Section VII. Attachment I.

information on any support services the Health Plans make available to their AMH contractors and how to access those services.

The Department has convened a Technical Advisory Group (TAG) to inform the development and evolution of the AMH program. The role of the AMH TAG is to advise and inform the Department on key aspects of AMH design and to provide feedback on proposed program changes. While TAG membership is by Departmental invitation only, all TAG meetings are open to the public, and AMH providers are encouraged to join meetings and share feedback during the public comment portion of each session. For more information on the AMH TAG, please see the AMH TAG page on the Department's Medicaid Transformation site.

Appendices

Appendix A. Standard Terms and Conditions for AMH Tier 1 and 2 Contracts

Health Plan will be required to include the following language in all contracts with AMH practices. These contracts terms are independent of practices' agreements with the Department and CCNC around Carolina ACCESS, and will not affect those agreements. The Department will review all Health Plan/AMH practice contract templates prior to use to ensure that standard contract terms are incorporated:

- Accept enrollees and be listed as a PCP in the Health Plan's enrollee-facing materials for the purpose of providing care to enrollees and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each enrollee.
- Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provide direct patient care a minimum of 30 office hours per week.
- Provide preventive services. (See Preventive Health Requirements table below.)
- Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees.
- Maintain a unified patient medical record for each enrollee following the Health Plan's medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the enrollee's medical record to the receiving practice upon the change of PCP at the request of the new PCP or Health Plan (if applicable) and as authorized by the enrollee within 30 days of the date of the request.
- Authorize care for the enrollee or provide care for the enrollee based on the standards of appointment availability as defined by the Health Plan's network adequacy standards.
- Refer for a second opinion as requested by the patient, based on Department guidelines and Health Plan standards.
- Review and use enrollee utilization and cost reports provided by the Health Plan for the purpose of AMH level utilization management and advise the Health Plan of errors, omissions, or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by the Health Plan for the purpose of participating in Health Plan or practice-based population health or care management activities.

Preventive Health Requirements:

			Required for providers that serve the following age ranges											
NCTracks Assigned Number	**Requirement**		**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary							Y		Y		Y	Y	Y

	Health Assessment													
2	Blood Lead Level Screening		Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to females only)							Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)		Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Vaccine Hib		Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing			Y	Y	Y	Y	Y	Y	Y	Y	Y		
8 and 9	Hemoglobin or Hematocrit		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine		Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)		Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)		Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental		Y	Y	Y	Y	Y	Y	Y					
16	Tetanus				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis									Y		Y	Y	Y
19	Varicella Vaccine		Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Appendix B. Standard Terms and Conditions for Health Plan Contracts with AMH Tier 3 Practices

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a Clinically Integrated Network (CIN) with which the practice has a contractual agreement that contains equivalent contract requirements.

a. Tier 3 AMH practices must be able to risk stratify all empaneled patients.
    i. The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the Health Plan are reconciled with the practice's panel list and up to date in the clinical system of record.
    ii. The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.
    iii. The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from Health Plan with clinical information to score and stratify the patient panel.
    iv. The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Department's program Policy of identifying "priority populations" for care management.
    v. The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.
    vi. The Tier 3 AMH practice must define the process and frequency of risk score review and validation.
b. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.
    i. The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.
    ii. The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:
        1. Patient's immediate care needs and current services;
        2. Other State or local services currently used;
        3. Physical health conditions;
        4. Current and past behavioral and mental health and substance use status and/or disorders;
        5. Physical, intellectual developmental disabilities;
        6. Medications;
        7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);
        8. Available informal, caregiver, or social supports, including peer supports.
    iii. The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job

responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.

iv. For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

c. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.

i. The Tier 3 AMH practice must develop the Care Plan within 30 days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.

ii. The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.

iii. The Tier 3 AMH practice must incorporate findings from the Health Plan Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.

iv. The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:

1. Measurable patient (or patient and caregiver) goals;
2. Medical needs, including any behavioral health needs;
3. Interventions;
4. Intended outcomes; and
5. Social, educational and other services needed by the patient.

v. The Tier 3 AMH practice must have a process to update each Care Plan as beneficiary needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.

vi. The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.

vii. The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.

viii. The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admission, discharge and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time.

ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).

1. Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
3. Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)

d. Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.
   i. The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:
      1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits
      2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
      3. NICU discharges;
      4. Clinical complexity, severity of condition, medications, risk score.
   ii. For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.
   iii. The Tier 3 AMH practice must include the following elements in transitional care management:
      1. Ensuring that a care manager is assigned to manage the transition
      2. Facilitating clinical handoffs;
      3. Obtaining a copy of the discharge plan/summary;
      4. Conducting medication reconciliation;
      5. Following-up by the assigned care manager rapidly following discharge;
      6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs
      7. Developing a protocol for determining the appropriate timing and format of such outreach.

e. Tier 3 AMH practices must use electronic data to promote care management.
   i. The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.

Appendix C. AMH Tier 3 Attestation Questions

Section A: Requirements (contact information)		
#	Requirement	Rationale/Description
N/A	Organization Name	The organization's legal name should be entered exactly as it appears in NCTracks, to facilitate matching.
N/A	Name and Title of Office Administrator Completing the Form	The form should be completed by the individual who has the electronic PIN required to submit data to NCTracks on behalf of the practice.
N/A	Contact Information of Office Administrator Completing the Form (email and phone number)	
N/A	Organization National Provider Identifier (NPI) or Individual NPI, for practitioners who do not bill through an organizational NPI	
N/A	Phone Number	This should be the general number and address used to reach the practice, as opposed to the specific contact information requested for the office administrator (above).
N/A	Email Address	
Section B: Medical Home Certification Process: Tier 3 Required Attestations		
Please indicate whether your practice, contracted CIN/Other Partners, or system can perform the following functions. (See supplemental questions 1-4 to provide more information about CIN/partner participation.)		
#	Requirement	Rationale
Tier 3 AMH practices must be able to risk-stratify all empaneled patients. To meet this requirement, the practice must attest to doing the following:		
1	Can your practice ensure that assignment lists transmitted to the practice by each Health Plan are reconciled with the practice's panel list and are up to date in the clinical system of record?	There is no set minimum interval at which practices should perform this review, but practices should develop a process to ensure that it is done when clinically appropriate. The clinical system of record is an electronic health record or equivalent.
2	Does your practice use a consistent method to assign and adjust risk status for each assigned patient?	Practices are not required to purchase a risk stratification tool; risk stratification by a CIN/partner or system would meet this requirement, or application of
3	Can your practice use a consistent method to combine risk scoring information received from the Health Plan with	

	clinical information to score and stratify the patient panel? (See supplemental question 5 to provide more information.)	clinical judgment to risk scores received from the Health Plan or another source will suffice.
4	To the greatest extent possible, can your practice ensure that the method is consistent with the Department's program policy of identifying "priority populations" for care management?	Not all care team members need to be able to perform risk stratification (for example, risk stratification will most likely be done at the CIN/partner level, or may be performed exclusively by physicians if done independently at the practice level), but all team members should follow stratification-based protocols (as appropriate) once a risk level has been assigned.
5	Can your practice ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice level) and that the methodology is applied consistently?	
6	Can your practice define the process and frequency of risk score review and validation?	Practices should be prepared to describe these elements for the Health Plan.
Tier 3 AMHs must provide care management to high-need patients. To meet this requirement, the practice must attest to being able to do all of the following:		
7	Using the practice's risk stratification method, can your practice identify patients who may benefit from care management?	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management, but care management designations need not precisely mirror risk stratification levels.
8	Can your practice perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs? The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum (see supplemental question 5 to provide further information): • Patient's immediate care needs and current services; • Other state or local services currently used; • Physical health conditions; • Current and past behavioral and mental health and substance use status and/or disorders; • Physical, intellectual developmental disabilities;	In preparation for the assessment, care team members may consolidate information from a variety of sources and must review the Initial Care Needs Screening performed by the Health Plan (if available). The clinician performing the assessment should confirm the information with the enrollee. After its completion, the Comprehensive Assessment should be reviewed by the care team members. The assessment should go beyond a review of diagnoses listed in the enrollee's

	• Medications; • Priority domains of social determinants of health (housing, food, transportation and interpersonal safety); and • Available informal, caregiver or social supports, including peer supports.	claims history and include a discussion of current symptoms and needs, including those that may not have been documented previously. This section of the assessment reviewing behavioral and mental health may include brief screening tools such as the PHQ-2 or GAD-7 scale, but these are not required. The enrollee may be referred for formal diagnostic evaluation. The practice or CIN/partners administering the Comprehensive Assessment should develop a protocol for situations when an enrollee discloses information during the Assessment indicating an immediate risk to self or others. The review of medications should include a medication reconciliation on the first Comprehensive Assessment, as well as on subsequent Assessments if the enrollee has not had a recent medication reconciliation related to a care transition or for another reason. The medication reconciliation should be performed by an individual with appropriate clinical training.
9	Does your practice have North Carolina licensed, trained staff organized at the practice level (or at the CIN/partner level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients?	Care managers must be assigned to the practice but need not be physically embedded at the practice location.
10	For each high-need patient, can your practice assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum	An enrollee may decline to engage in care management, but the practice or CIN/partners should still assign a care manager

	credential of RN or LCSW? (See supplemental question 6 to provide further information.)	and review utilization and other available data in order to inform interactions between the enrollee and their clinician during routine visits.
For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan.		
11	Can your practice develop the Care Plan within 30 days of Comprehensive Assessment or sooner if feasible while ensuring that needed treatment is not delayed by the development of the Care Plan?	30 days is the maximum interval for developing a Care Plan. If there are clinical benefits to developing a Care Plan more quickly, practices should do so whenever feasible
12	Can your practice develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible?	Practice may identify their own definitions of 'individualized', 'person-centered' and 'collaborative', but should be able to describe how their care planning process demonstrates these attributes
13	Can your practice incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan? Can your practice include, at a minimum, the following elements in the Care Plan o Measurable patient (or patient and caregiver) goals o Medical needs including any behavioral health needs; o Interventions; o Intended outcomes; and o Social, educational, and other services needed by the patient.	Intended outcomes can be understood as clinical steps identified by the care team that will lead to the enrollee/caregiver-defined goal. For example, the enrollee may set a goal of no longer needing frequent fingersticks and injected insulin. The care team may develop an intended clinical outcome that represents the level of glycemic control at which the enrollee could attempt a trial of oral hypoglycemics, and a second intended clinical outcome that represents the level of control on oral hypoglycemics that would allow the enrollee to continue with the regimen
14	Does your practice have a process to update each Care Plan as beneficiary needs change and/or to address gaps in care; including, at a minimum, review and revision upon	There is no set minimum interval at which practices should perform this review but practices should develop a process to

	reassessment? (See supplemental question 7 to provide more information.)	ensure that it is done when clinically appropriate
15	Does your practice have a process to document and store each Care Plan in the clinical system of record?	The clinical system of record may include an electronic health record.
16	Can your practice periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary?	There is no set minimum interval at which practices should perform this review but practices should develop a process to ensure that it is done when clinically appropriate
17	Can your practice track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time?	While not required, practices are also encouraged to develop systems to ingest ADT information into their electronic health records or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s)
18	Can your practice or CIN/partners implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)? • Real-time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions – for example, arranging rapid follow-up after an ED visit to avoid an admission • Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital • Within a several-day period to address outpatient needs or prevent future problems for high-risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge)	Practices (directly or via CIN/partners) are not required to respond to all ADT alerts in these categories, but they are required to have a process in place to determine which notifications merit a response and to ensure that the response occurs. For example, such a process could designate certain ED visits as meriting follow-up based on the concerning nature of the patient's complaint (suggesting the patient may require further medical intervention) or the timing of the ED visit during regular clinic hours (suggesting that the practice should reach out to the patient to understand why he or she was not seen at the primary care site). The process should be specific enough – with regard to the designation of ADT alerts as requiring or not

		requiring follow-up, the interval within which follow-up should occur, and the documentation that follow-up took place – to enable an external observer to easily determine whether the process is being followed.
Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are at risk of readmission and other poor outcomes.		
19	Does your practice have a methodology or system for identifying patients in transition who are at risk of readmission and other poor outcomes that considers all of the following? • Frequency, duration and acuity of inpatient; SNF and LTSS admissions or ED visits • Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, or a medically supervised or alcohol/drug abuse treatment center • NICU discharges • Clinical complexity, severity of condition, medications and risk score	
20	For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, can your practice assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credential of RN or LCSW? (Please see supplemental question 8 to provide further information.)	An enrollee may decline to engage in care management, but the practice or CIN/partners should still assign a care manager and review utilization and other available data in order to inform interactions between the enrollee and the clinician during the transition period.
21	Does your practice include the following elements in transitional care management? • Ensuring that a care manager is assigned to manage the transition • Facilitating clinical handoffs • Obtaining a copy of the discharge plan/summary • Conducting medication reconciliation • Following up by the assigned care manager rapidly following discharge	The AMH practice is not required to ensure that follow-up visits occur within a specific time window because enrollees' needs may vary. However, the practice must have a process for determining a clinically appropriate follow-up interval for each enrollee that is specific enough – with regard to the

	• Ensuring that a follow-up outpatient, home visit or face-to-face encounter occurs • Developing a protocol for determining the appropriate timing and format of such outreach	interval within which follow-up should occur and the documentation that follow-up took place – to enable an external observer to easily determine whether the process is being followed.
Tier 3 AMH practices must use electronic data to promote care management.		
22	Can your practice receive claims data feeds (directly or via a CIN/partner) and meet Department-designated security standards for their storage and use?	

Section C includes supplemental questions that practices are required to answer, although the content of their answers will not affect their Tier placement. The Department will use this information to track how AMH practices perform their core care management functions and work with CINs/partners.

Supplemental Questions		
Please indicate whether your practice, or contracted CIN, can perform the following functions. (See supplemental questions 1-3 to provide more information about CIN participation.)		
S1	Will your practice work with a CIN or Other Partners?	This element must be completed, but responses will not affect certification.
S2	If yes, please list the names and regions of the CIN(s) or Other Partners you are working with.	This element must be completed, but responses will not affect certification. This list should include the full legal name of each CIN.
S3	Who will provide care management services for your AMH? (e.g., CIN or other CM vendor) ☐ Employed practice staff ☐ Staff of the CIN ☐ Staff of a care management or population health vendor that is not part of a CIN ☐ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.
S4	If you are working with more than one CIN/partner, please describe how CINs/partners will share accountability for your assigned population.	This element must be completed, but responses will not affect certification. When practices elect to work with multiple CINs/partners, they can divide their population among CINs/partners based on regional or other categorizations, but they

		should ensure that they can readily identify which CINs/partners have primary accountability for which patients.
S5	Practices/CINs/partners will have the option to assess adverse childhood experiences (ACEs). Can your practice/CIN/partner assess adults for ACEs?	This element must be completed, but responses will not affect certification.
S6	What are the credentials of the staff who will participate in the complex care management team within practice/CIN/partner? (Please indicate all that apply.) ☐ MD ☐ RN ☐ LCSW ☐ Medical Assistant/LPN ☐ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.
S7	For patients who need LTSS, can your practice coordinate with the Health Plan to develop the Care Plan?	This element must be completed, but responses will not affect certification. Practices and CINs/partners are not required to have the same capabilities as the Health Plan for screening and management of LTSS populations.
S8	What are the credentials of the staff who will participate in the transitional care management team within the practice/CIN/partner? (Please indicate all that apply.) ☐ MD ☐ RN ☐ LCSW ☐ Medical Assistant/LPN ☐ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.

Appendix D. North Carolina Integrated Care for Kids (InCK) Model for AMH Tier 3 Practices

Section D1: NC Integrated Care for Kids (NC InCK) Overview

North Carolina Integrated Care for Kids (InCK) is a state-funded payment and service delivery model of integrated care for children insured by Medicaid and CHIP. InCK is supported by CMS grant funding designed to improve outcomes for children. InCK aims to:

1. **Understand Needs:** More holistically understand the needs of children and youth;
2. **Support and Bridge Services:** Integrate services across sectors for children and youth who could benefit from additional support; and
3. **Focus Healthcare Investments:** Find ways to invest resources into what matters most for children, youth, and families.

Implementation of InCK in North Carolina is led by a team that spans Duke University, the University of North Carolina and DHHS (jointly known as "NC InCK").[1] NC InCK will take effect on January 1, 2022 and run through December 31, 2026.

Eligibility of Children and Youth for NC InCK

Medicaid and CHIP-insured children and youth ages 0-20 whose Medicaid administrative county is one of the following will be automatically enrolled in InCK starting in January 2022: Alamance, Durham, Granville, Orange, and Vance. DHHS will centrally maintain beneficiary- level data on children and youth participating in NC InCK, will update it monthly and will share the data with Standard Health Plans as described below.

NC InCK Components

InCK will be focused on integrating care across ten **core child services**:

- Physical and Behavioral Health
- Early Care and Education
- Housing
- Food
- Schools
- Title V
- Child Welfare
- Mobile Crisis Response Services
- Juvenile Justice
- Legal Services

To integrate care across these core child services and test the effect on outcomes, NC InCK adds the following new components included in Appendix D and Appendix E to the existing care management and data exchange requirements that exist within Health Plan contracts and AMH Tier 3 practices as described above. AMH Tier 3 practices take responsibility for care management and population health for their Medicaid managed care patients, allowing them to have a uniform platform of care management across the different Health Plans with which they contract. Clinically Integrated Networks (CINs) and Other

[1] For more information, see NC InCK website: https://ncinck.org/

Partners often play a role in organizing the work across Tier 3 AMH practices and helping practices carry out the required care management responsibilities.

For children in InCK who are assigned to AMH Tiers 1 and 2, the PHP will be responsible for the care management components described below.

NC InCK incorporates the following design features:

- **Service Integration Levels** (SILs): NC InCK will use cross-sector data to stratify children into three Service Integration levels. SILs use cross-sector data from state child welfare, juvenile justice, school attendance and suspensions, in addition to Medicaid data, to assign a SIL of 1, 2 or 3 to each individual. The SILs will then be shared with Health Plans and AMHs (as described below) to inform care management. InCK members in SIL 2 and SIL 3 will be "priority populations" for PHPs and AMH Tier 3s. InCK members in SIL 3 will be assigned a "High" risk designation.

- **Family Navigator:** In NC InCK, children in SIL 2 or 3 will be assigned a **Family Navigator**, who is part of the care management team. All children assigned to an AMH Tier 3 who signs an amendment to participate will receive outreach for assignment of a Family Navigator. The Family Navigator will work directly with the child and family to help the child and family meet health, social and educational goals. Family Navigators are part of the care team and can be based at the AMH or the CIN, depending on the practice's relationship with a CIN. The Family Navigator role may be performed by an existing care manager on the care management team and may be an RN, MSW, BSW, CHW, LPN, Population Health Specialist or equivalent, but the person assigned the role should be consistent for each child enrolled in InCK. The Family Navigator will hold a specific set of InCK responsibilities for the member outlined below.

- **Shared Action Plan and Integrated Care Platform**: The Family Navigator will work with the child and family to develop a **Shared Action Plan (SAP)** with the family, which is a brief, actionable plan in a standard format set by NC InCK for improved family-centered, whole-child service coordination. The SAP must be stored in the AMH's care management record but also should be shared with the InCK care teams if a Consent Agreement has been signed. For InCK, the SAP will be stored on the **InCK Integrated Care Platform** maintained by InCK. The InCK Integrated Care Platform is a standardized, Internet-accessible care integration tool that InCK staff and other authorized personnel will use to create, store, view, update and share InCK member information, including but not limited to basic InCK member data and the SAP.

- **Integration Consultant:** To support implementation of NC InCK, health plans, CINs and other core child service sectors employ Integration Consultants, whose role is specifically to support Family Navigators and care teams in the InCK model. Each InCK member in SIL 2 and SIL 3 will be assigned an Integration Consultant who is available to support the Family Navigator working with the member. Integration Consultants do not have direct contact with InCK members.

- **Integrated Care Team**: An integrated care team is a family-driven team of professional and natural supports that collaborate to support an InCK member and their family in meeting the health, education and social service needs identified by the family. In InCK, care teams are intentionally cross-sector, including both healthcare providers and those from schools, early childhood, and, if applicable, sectors like child welfare and juvenile justice.

- **Enhanced Data Exchange:** Health Plans will share additional information with AMH Tier 3s serving InCK Members and AMH Tier 3s will be required to complete additional reporting requirements, as described below.

- **Quality Measure Reporting and Tracking**: NC InCK will track specific measures in addition to the AMH Measure Set, as described below. AMH Tier 3s serving InCK Members will receive feedback on the InCK measure set.

- **Alternative Payment Model (APM):** AMH Tier 3s serving InCK Members will be eligible to participate in the InCK APM. More details on the InCK APM are forthcoming. As with other AMH APMs, Health Plans can offer these InCK APMs for AMH Tier 1 and 2 practices but are not required to do so.

Role of AMH Tier 3 Practices and CINs/Other Partners in NC InCK

The role of AMH Tier 3s in NC InCK follows the same logic and principles as the broader AMH program described in this Manual. AMH Tier 3 practices have responsibility for care management that is based in the community for high and rising risk Health Plan members, whether that responsibility is organized at the practice level, at the CIN/Other Partner level or a combination. For children and youth who are identified by NC InCK as part of the NC InCK model and are attributed to AMH Tier 3s, those AMH Tier 3s (or CINs/Other Partners on their behalf) are responsible for the enhanced components of the care management, data exchange and quality measurement that are being tested in NC InCK. These requirements are set out in Section 2 below. AMH Tier 3s that serve NC InCK-attributed children and youth and participate in the InCK program are required to follow the below requirements in addition to the requirements for AMH Tier 3 practices described above in this manual. As described below, expectations for AMH Tier 3 practices are encapsulated in a set of standard terms and conditions to be integrated in contracts with Health Plans. No additional attestation is required from AMH Tier 3 practices.

Section D2: InCK AMH Tier 3 Practice Requirements

Requirement 1: Use the SIL to refine Risk Stratification for Members assigned to InCK.

NC InCK will centrally assign each InCK Member into one of three SILs, based on clinical and non-clinical data. This process will use healthcare utilization, diagnoses, school-based data (attendance and suspensions), data from key social services like child welfare, juvenile justice, as well as direct feedback from families on social service needs in areas like food, housing and transportation to assign each Member an SIL. DHHS will transmit Member-level SILs to each PHP, and Health Plans will be responsible for transmitting InCK Member SILs each month to AMH Tier 3s.

Table 1. Standard Terms and Conditions: Risk Stratification

AMH Tier 3 Practices Must …	Additional Information
1.1 Use the SIL assigned to each Member to outreach members in SIL 2 and 3 for assessment and care management.	• AMH Tier 3s will receive the InCK SIL for each InCK member monthly on the Patient Risk List transmitted by Health Plans. • Members assigned to SIL 2 and SIL 3 should be considered "priority populations" for the InCK integrated care support model regardless of their Health Plan assigned stratification. • Both members in SIL 2 and SIL 3 will receive outreach for InCK care management and engaged members should be assigned a Family Navigator, regardless of the Health Plans Risk Score Category. • Health Plans will ensure all members assigned to SIL 3 are designated a Risk Score Category of "High" on the Patient Risk List sent downstream to AMH Tier 3s.
1.2 Ensure that the SIL assigned to the InCK member is reconciled each month in the clinical system of record.	• AMHs should reconcile and update the SIL assigned to InCK members monthly with the transmission of the Patient Risk List from Health Plans. • AMHs are required to maintain the member's SIL in their care management system, and best practice is to also provide the SIL for the member in the system of record for primary care providers and other clinical teams.

Requirement 2: Provide Integrated Care Support to InCK Priority Populations.

InCK members assigned to SIL 2 and SIL 3 are considered "priority populations" likely to benefit from integrated care support (i.e. care management facilitated by the Family Navigator that spans the ten InCK core child services). All members in SIL 2 and SIL 3 should receive outreach for InCK's integrated care model and assignment of a Family Navigator. Outreach practices should mirror those used for enrolling other populations with "high" risk in care management. InCK's care management model is similar for members in SIL 2 and 3 with two exceptions: requirements for comprehensive assessment (i.e., required for all members in SIL 3) and requirements for Shared Action Plan (i.e., required to be offered for all members in SIL3).

Table 2. Standard Terms and Conditions: Integrated Care Support in InCK

AMH Tier 3 Practices Must …	Additional Information
2.1 Coordinate with Health Plans to screen members for food and housing needs for all InCK members assigned to SIL 1 and 2 at least annually, and to all patients in SIL 3 every 6 months.	To maximize screening or food and housing rates in InCK, NC Medicaid expects Health Plans and AMH Tier 3 practices or their CINs or other partners to work together. AMH Tier 3 practices (or CINs/other partners) can conduct screenings within routine visits or direct member outreach. The intent is to facilitate and streamline PHP and AMH collection and reporting of complementary data on members. Medicaid will seek input on screening questions and data collection from AMH Tier 3s and associated CINs and additional guidance for AMH Tier 3 practices (or CINs/other partners) is forthcoming in 2022 on screening requirements and reporting for InCK.
2.2 AMH Tier 3's should perform a Comprehensive Assessment on each Member assigned to SIL 3 within 30 calendar days of member (guardian/caregiver/parent) agreeing to integrated care management services (engagement). The Comprehensive Assessment for InCK enrolled members should also include assessing these additional InCK domains: educational needs, child welfare needs, and juvenile justice needs.	• InCK members assigned to SIL 3 are those currently in an out of home placement or at high-risk of entry or re-entry. AMH Tier 3s are encouraged and have flexibility to use a pediatric-focused comprehensive assessment tool and use information collected to support pre-population of some components of the InCK Shared Action Plan and InCK consent. Family Navigators administering the Comprehensive Assessment can also use information collected to start establishing an InCK member's integrated care team. • AMH Tier 3 practices or their CINs or other partners can also complete a Comprehensive Assessment on InCK members assigned to SIL2 to better understand their holistic needs, but it is not required at this time.
2.3 Assign a Family Navigator to all SIL 2 and SIL 3 members who agree to participate in care management as part of the integrated care management team. At a minimum, the InCK Family Navigator will: 1) Serve as the member's single point of contact; 2) Communicate with the member's guardian at least quarterly for a period of a year on their	• Family Navigators are part of the care management team and can be existing staff within the AMH Tier 3 (or CIN) with responsibilities for care management and components of InCK's pediatric integrated care model. • InCK requirements for length and

integrated care needs and make referrals; 3) Identify and convene the integrated care team as defined together with the member's guardian, 4) Support service referrals across InCK's 10 core child service areas; and 5) Ensure that an InCK Shared Action Plan is completed for at least 30% of SIL 3 members and at least 10% of SIL 2 members. 6) Attend at least 60% of all Family Navigator capacity building events organized by NC InCK each year.	frequency of care management are minimum requirements. AMH Tier 3 practices, their CINs or partners can engage with higher frequency or longer duration based on the needs of the member. • Please reference InCK's website (www.ncinck.org) for in-depth guidance on integrated care team formation, the Shared Action Plan, and navigating the InCK 10 core child service areas. • Family Navigator capacity building events will be held monthly for a period of 1.5 hours.
2.4 For each member in SIL 2 and SIL 3, use the InCK standardized Consent Form to support care team collaboration, access to the InCK integrated care platform, and the Shared Action Plan, all of which facilitate integrated care for the Member across InCK's 10 core child service areas. Any completed consent form should be shared with the member's InCK Integration Consultant for records maintenance.	The intent of InCK's Consent Form is to promote 2-way information sharing between care team members in healthcare and any other service providers desired by the member (e.g., behavioral health, schools, early childhood, child welfare, juvenile justice). Signing the Consent Form also gives integrated care team members access to the member's profile on the InCK Integrated Care Platform (Virtual Health). The InCK consent form, Family Navigator training on consent, and InCK's Guide to an Integrated Care team will be available at www.ncinck.org
2.5 For each member in SIL 2 and SIL 3 actively engaged in integrated care management, convene the InCK member's integrated care team and family to align on cross-sector goals and methods of communicating to meet the member's integrated care needs.	• An integrated care team is a family-driven team of professional and natural supports that collaborate to support an InCK member and their family in meeting the health, education and social service needs identified by the family. • Not all integrated care team members are required to attend a care team meeting, but Family Navigators should provide avenues for each care team member to contribute to the coordination for the child either prior to or after the meeting and should be included on correspondence and action steps after the meeting. • Meetings convened to create the Shared Action Plan (SAP) or other existing care team meetings (e.g., care management meeting with school or child welfare) may

	be used to meet this integrated care team convening requirement if a meeting structure is already working well for the family.
2.6 For members in SIL 2 and 3, provide assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, which should also include WIC, Free and Reduced Lunch, and school-based services for members with exceptional needs.	This requirement adds three service areas -- WIC, FRL and school-based services -- to the previous list of benefits care management teams are outlined to support in the care management model.

Requirement 3: Develop a Shared Action Plan for 30% of InCK members assigned to SIL 3 and at least 10% of members assigned to SIL 2

Membership in InCK does not change any of the existing AMH Tier 3 requirements for creation of a care plan for members as outlined in Table 3. "Standard Terms and Conditions: Developing a Care Plan for All Patients Receiving Care Management". AMH Tier 3 practices will also be responsible for working with families of InCK members to complete a brief, strengths focused InCK Shared Action Plan (SAP) for InCK members assigned to Service Integration Level (SIL) 2 and SIL 3.

The Shared Action Plan (SAP) is a shareable, living document created in collaboration between the Family Navigator, family and the member's integrated care team to encourage coordination among care team members and natural supports. The Shared Action Plan (SAP) is an important tool designed to support a conversation with families and their integrated care team on the cross-sector goals and needs for the InCK member and provide an easy-to-navigate roster of services and contact information for all members of the care team. An InCK Consent Form will also be provided for completion to support in the sharing of the SAP after completion. InCK has set specific minimum targets detailed below for completion of this new integrated care document, but encourages broad use of the SAP.

NC InCK created a Shared Action Plan guide to support Family Navigators in completing the document on their website (www.ncinck.org).

Table 3. Standard Terms and Conditions: Shared Action Plan Development

AMH Tier 3 Practices Must …	Additional Information
3.1 For at least 30% of InCK members assigned to SIL 3 and at least 10% of InCK members assigned to SIL 2, complete a InCK Shared Action Plan (SAP) with the family and integrated care team within 30 days of the Comprehensive Assessment being completed. The SAP should be completed with input and participation from the majority of the integrated care team members. The ideal is that the majority of the care team convene at a time when they can	• For a subset of members with high needs for integrated care, the Family Navigator listed in requirement 2 must also work collaboratively with the family and care team to complete a 3-page Shared Action Plan (SAP) template. Scripts, templates and best practices for facilitation will be available on the NC InCK website (ncinck.org) and through the Integration Consultants. 30 days is the maximum

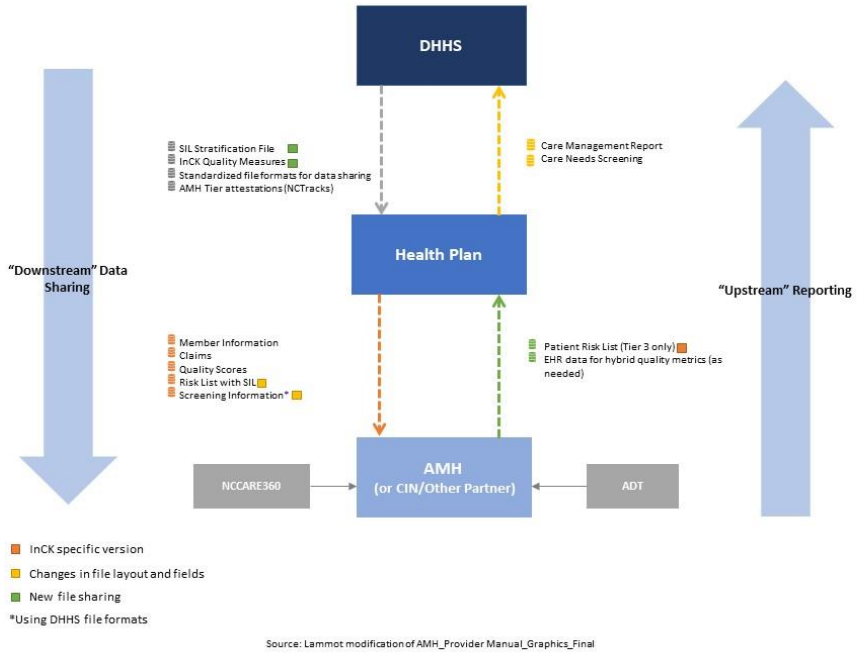
discuss the plan together and with the family.	interval for developing a Shared Action Plan. If there are clinical benefits to developing a Shared Action Plan more quickly, practices should do so whenever feasible. • Not all integrated care team members are required to attend the SAP creation meeting, but Family Navigators should provide avenues for each care team member to contribute to the plan either prior to, during, or after the SAP meeting before the final SAP is distributed to the full integrated care team listed on the InCK consent. Most importantly, the SAP is not a tool to be created in a 1:1 meeting between the family and Family Navigator; instead, the SAP should be created with the inclusion of a care team. • CINs and AMH Tier 3s can use their comprehensive assessment process to initiate some components of the SAP with members ahead of the SAP meeting; including contact information, needs, and strengths. Information collected in the comprehensive assessment should be reviewed with the full care team in the meeting. • AMHs or their CIN/other partner are strongly encouraged to use the SAP template created by InCK because it was designed with families to be family-friendly and facilitate integrated care team participation. However, if AMH Tier 3 practices or their CIN/other partner would like to use an alternative template (e.g., an existing form in their system of record to store and create the SAP) they must seek approval from NC Medicaid (via Leonard.A.Croom@dhhs.nc.gov) on both the format and method of distributing the SAP to the child's integrated care team. All alternative SAP formats must include a care team roster.
3.2 For members offered a Shared Action Plan, support the Member in completing the InCK consent process to support sharing of the SAP and ongoing care team collaboration via the InCK Consent Form. Any completed consent form should be shared with	NC InCK has designed a consent form to support Family Navigators in sharing the Shared Action Plan after completion and to facilitate ongoing care team collaboration on behalf of the member. This is the same

the member's InCK Integration Consultant for records maintenance.	Consent Form listed in 2.6.

Requirement 4: Receive and send claims data feeds and other specified data elements in accordance with state-designated security standards.

To help support InCK participants' risk and needs, AMH Tier 3s will receive additional data elements in the current reports from Health Plans in a standardized format. AMH Tier 3s will be required to provide additional information on InCK participants to the Health Plans based on the guidance in Table 4 below.

Figure 1. InCK Data Flow



Source: Lammot modification of AMH_Provider Manual_Graphics_Final

Table 4. Standard Terms and Conditions: InCK Data Requirements

AMH Tier 3 Practices Must …	Additional Information
4.1. Receive and use data from Health Plans on InCK-specific data elements such as InCK attributed members and SILs in the following reports and as specified in the AMH Provider Manual and InCK Technical Specifications: • Patient Risk List; • Care Needs Screening Results ;	Patient Risk List will include SIL stratification for InCK participants as indicated in the Priority Population. AMH Tier 3s will use the SIL information in the Patient Risk List to provide assessment and care management services to these priority populations as outlined in Table 2.

• Quality Measure results.	
4.2 Send data to the PHP on InCK-specific data elements and as specified in the AMH Provider Manual and InCK Technical Specifications, including: • Patient Risk List;	AMH Tier 3s and their CIN/other partners will provide information on the Patient Risk List about • Family Navigator assignment • Dates related to outreach • Shared Action Plan creation • Phone and email contact information for the assigned Family Navigator

Section D3. Quality Measures and InCK

NC InCK has developed a model where quality of care is measured and improved using both standard health care measures (e.g., proportion of children receiving well-child checks) and novel cross-sector, well-being measures (e.g., kindergarten readiness, chronic absenteeism from school, food insecurity, housing stability). The technical specifications for all NC InCK measures is available in the NC InCK Performance Measure Technical Specifications. This model leverages the NC government's multi-sector data to compile and calculate many of the quality measures for this program.

All Tier 3 AMH practices will be required to collect and send additional data to an existing feed (Patient Risk List) and begin reporting responses to SDOH (Health Opportunities) screening questions and sharing those with Health Plans using a standardized template as described in Figure 2 below. Table 4 *Standard Terms and Conditions: InCK Data Requirements* above describes this requirement. These additional data sharing requirements will enable DHHS to calculate all the quality measures for this program.

The data for the Kindergarten Readiness measure (Figure 3 below) will be collected using a new billable code available to all AMH Tier 3s. AMH Tier 3s participating in the APM will need to use this billable code in order to receive credit for this measure.

- **"NC InCK CMS measures"**
    - All Tier 3 AMH practices will share data with their contracted Health Plans so that it will be included in the calculation of these measures.
    - These measures will be reported to CMS at an individual patient level.
    - For those AMH Tier 3 practices who participate in an InCK APM, their performance on these measures will not be considered for purposes of achieving an incentive payment in an InCK APM.

- "**NC InCK APM measures**"
    - All Tier 3 AMH practices will share data with their contracted Health Plans as described in

Figure 2 below so that it will be included in the calculation of these measures.

- All Tier 3 AMH practices will receive performance data on these measures from their contracted Health Plans using a standardized DHHS format.
- Only providers who enroll in an InCK APM with their contracted Health Plans will have the opportunity to earn an incentive based on their performance on these measures.

Figure 2. AMH Tier 3 InCK Required Reporting

Performance Measure	Reporting Chain	Notes
Required of All Tier 3 AMHs		
Shared Action Plan for children in SIL-2 and SIL-3 engaged in integrated care management	AMH > Health Plan > Medicaid	AMHs and their CINs/other partners will share data on the Patient Risk List.

Figure 3. NC InCK CMS Measures and InCK APM Measures

*Note: Full measure technical specifications are available in the NC InCK Measure Specifications and NC Medicaid Managed Care Quality Measurement Technical Specifications Manual. NC InCK will send data only to CMS on metrics indicated with an * on all InCK eligible members*

Measure	Brief Description
NC InCK CMS Measures	
Child and Adolescent Well Child visits*	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit during the measurement year.
Follow-Up After Hospitalization for Mental Illness*	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.
Use First-Line Psychosocial Care for Children/Adolescents on Antipsychotics (APP)*	The percentage of children and adolescents who had a new prescription for an antipsychotic medication without a primary indication for it and had documentation of psychosocial care as first-line treatment.
NC InCK APM Measures: Cross Sector	
Kindergarten Readiness Rate	% of Kindergarten students at or above development and learning expectation in the Early Learning Inventory, an observation-based formative assessment across 5 domains of early learning and development. Source: NC Dept of Public Instruction
Primary Care Kindergarten Readiness Bundle	% of patients birth to 5 years who received kindergarten readiness bundle defined as a minimum of 5 universal and need-based interventions based on their eligibility and age
Housing Instability Rate	% of survey respondents who answer one or more of the three standardized housing stability survey questions from PRAPARE with ‘yes’. These questions are part of the Care Needs Screen that are currently being administered by Health Plans to all Medicaid beneficiaries.

Screening for Housing Instability	% of InCK-attributed children who have been screened for housing instability using the standardized survey questions from PRAPARE. These questions are part of the Care Needs Screen that are currently being administered by Health Plans to all Medicaid beneficiaries.
Food Insecurity Rate	% of survey respondents who answer one or both of the standardized Hunger Vital Signs survey statements with 'often true' or 'sometimes true'. These statements are part of the Care Needs Screen that are currently being administered by Health Plans to all Medicaid beneficiaries.
Screening for Food Insecurity	% of InCK-attributed children birth to age 20 who have a documented response to at least one of the standardized Hunger Vital Signs survey statements. These statements are part of the PHP Care Needs Screen that are currently being administered to all Medicaid beneficiaries.
NC InCK APM Measures: Health Care	
Ambulatory Care: ED visits	Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19.
Screening for Clinical Depression and Follow-Up Plan	% of NC InCK-attributed patients ages 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter.
Shared Action Plan for children in SIL 2 and SIL 3	Percentage of children in NC InCK Service Integration Level 2 and Service Integration Level 3 who have a Shared Action Plan that is accessible to the child/family and their integrated care team
Well-Child Visits in the First 30 Months of Life (Disparity Measure)	The percentage of NC InCK-attributed children who had the following number of well-child visits during the last 15 months: • Children who turned 15 months old during the measurement year with six or more well-child visits. • Children who turned 30 months old during the measurement year with two or more well-child visits.
Total cost of care	To Be Determined Based on NC Medicaid Guidance

Section D4: InCK Practice and Care Management Supports and Other Resources

InCK Website and Guides: Ahead of and after launch in January 2022, please refer to the NC InCK website (www.ncinck.org) for additional program-related resources. The website will also house a range of materials to support Family Navigators in fulfilling their responsibilities under the model, including,

- Family Navigator Handbook
- Health Care Provider Playbook
- InCK Guide to the Shared Action Plan and Integrated Care Teams
- InCK Consent Form and Training

- Talking points and FAQs for beneficiary communication
- Core Child Service guides for Child Welfare, Housing, Food, Early Childhood, Schools, Behavioral Health, Public Health, Juvenile Justice, and Legal Aid

Monthly Webinars on Pediatric Integrated Care: Starting in 2022, InCK will also host monthly capacity building on pediatric care management topics via webinar for AMH care management teams to support implementation of the InCK model. Each month will focus on a component of the InCK model or different core child service area (i.e. early childhood, housing) and will bring together experts in the field to support care managers in meeting these sector-specific needs of beneficiaries.

Appendix E: InCK Standard Terms and Conditions for Health Plan Contracts with AMH Tier 3 Practices

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice or by a Clinically Integrated Network (CIN) with which the practice has a contractual agreement that contains equivalent contract requirements. The InCK Standard Terms and Conditions are in addition to the existing AMH Standard Terms and Conditions in Appendix B.

The Tier 3 AMH practice must:

1. **Use the SIL to refine Risk Stratification for Patients assigned to InCK.**
   - 1.1. Use the SIL assigned to each patient to outreach patients in SIL 2 and 3 for assessment and care management.
   - 1.2. Ensure that the SIL assigned to the InCK patient is reconciled each month in the clinical system of record.

2. **Provide Integrated Care Support to InCK Priority Populations.**
   - 2.1. Coordinate with Health Plans to screen members for food and housing needs for all InCK patients assigned to SIL 1 and 2 at least annually, and to all patients in SIL 3 every 6 months.
   - 2.2. AMH Tier 3's should perform a Comprehensive Assessment on each Member assigned to SIL 3 within 30 calendar days of member (guardian/caregiver/parent) agreeing to integrated care management services (engagement). The Comprehensive Assessment for InCK enrolled patients should also include the educational needs, child welfare needs, and juvenile justice needs of the patient in addition to all current required domains.
   - 2.3. Assign a Family Navigator to all SIL 2 and SIL 3 members who agree to participate in care management as part of the integrated care management team. At a minimum, the InCK Family Navigator will:
     - Serve as the patient's single point of contact;
     - Communicate with the patient's guardian at least quarterly for a period of a year on their integrated care needs and make referrals;
     - Identify and convene the integrated care team as defined together with the patient's guardian,
     - Support service referrals across InCK's 10 core child service areas; and
     - Ensure that an InCK Shared Action Plan is completed for at least 30% of SIL 3 patients and at least 10% of SIL 2 patients.
     - Attend at least 60% of all monthly Family Navigator capacity building events organized by NC InCK each year.
   - 2.4. For each patient in SIL 2 and SIL 3, use the InCK standardized Consent Form to support care team collaboration, access to the InCK integrated care platform, and the Shared Action Plan, all of which facilitates integrated care for the patient across InCK's 10 core child service areas. Any completed consent form should be shared with the patient's InCK Integration Consultant for records maintenance.
   - 2.5. For each member in SIL 2 and SIL 3 actively engaged in integrated care management, convene the InCK member's integrated care team and family to align on cross-sector goals and methods of communicating to meet the member's integrated care needs.
   - 2.6. For patients in SIL 2 and 3, provide assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, which should also include WIC, Free and Reduced Lunch, and school-based services for patients with exceptional needs.

3. **Develop a Shared Action Plan for at least 30% of InCK patients assigned to SIL 3 and at least 10% of patients assigned to SIL 2.**
   3.1. For at least 30% of InCK patients assigned to SIL 3 and at least 10% of InCK patients assigned to SIL 2, complete a InCK Shared Action Plan (SAP) with the family and integrated care team within 30 days of the Comprehensive Assessment being completed. The SAP should be completed with input and participation from the majority of the integrated care team members. The ideal is that the majority of the care team convene at a time when they can discuss the plan together and with the family. Any completed consent form should be shared with the member's InCK Integration Consultant for records maintenance
   3.2. For patients offered a Shared Action Plan, support the patient in completing the InCK consent process to support sharing of the SAP and ongoing care team collaboration via the InCK Consent Form. Any completed consent form should be shared with the member's InCK Integration Consultant for records maintenance.

4. **Receive and send claims data feeds and other specified data elements in accordance with state-designated security standards.**
   4.1. Receive and use data from Health Plans on InCK-specific data elements such as InCK attributed patients and SIL levels, in the following reports and as specified in the AMH Provider Manual and InCK Technical Specifications:
   - Patient Risk List;
   - Care Needs Screening Results;
   - Quality Measure results.

   4.2. Send data to the PHP on InCK-specific data elements as specified in the AMH Provider Manual and InCK Technical Specifications, including:
   - Patient Risk List;

Appendix F. Healthy Opportunities Pilots Guidance for AMH Tier 3 Practices

Section I: Overview of Pilots

North Carolina's transition to Medicaid managed care will include the launch of the Healthy Opportunities Pilots ("the Pilots") in 2022. The Pilots present an unprecedented opportunity to test the impact of providing evidence-based, non-medical interventions to Medicaid enrollees. In October 2018, the Centers for Medicare and Medicaid Services (CMS) authorized up to $650 million in state and federal Medicaid funding to cover the cost of providing select Pilot services that address non-medical drivers of health in four priority domains: housing, food, transportation, and interpersonal violence/toxic stress. While access to high-quality medical care is critical, research shows that up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.[2] A substantial body of research has established that having an unmet resource need – including experiencing housing instability,[3] food insecurity,[4] unmet transportation needs,[5] and interpersonal violence or toxic stress[6,7] – can significantly and negatively impact health and well-being, as well as increase health care utilization and costs.[8,9]

The Pilots allow for North Carolina's Medicaid managed care plans ("Prepaid Health Plans (PHPs)"), providers, and community-based organizations to have the tools, infrastructure, and financing to integrate non-medical services, such as medically tailored home delivered meals or short-term post hospitalization housing, that are directly linked to health outcomes into the delivery of care. The Department has developed the Healthy Opportunities Pilots Fee Schedule (Appendix B) to define and price these non-medical interventions. The Pilots will test whether the Pilot services, which will be delivered by local community-based organizations and social services agencies called human service organizations (HSOs), can improve health outcomes and/or reduce health care costs for Medicaid managed care enrollees experiencing certain health needs and social risk factors.

Most Human Service Organizations (HSOs) that deliver Pilot services will be incorporated into the health care system for the first time through the Pilots. While many HSOs traditionally rely on grant funding, in the Pilots they will operate as Medicaid providers by invoicing for delivered services based on a fee schedule. To operationalize the fundamental shift in business processes for these organizations, there must be infrastructure and procedures in place to assist HSOs in invoicing and paying for Pilot services. These processes should seek to build HSO capacity while minimizing burden to ensure that HSOs are able to effectively participate in the Pilots.

---

[2] Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010

[3] A. Simon, et al. "HUD Housing Assistance Associated with Lower Uninsurance Rates and Unmet Medical Need." Health Affairs, June 2017

[4] A.Coleman-Jensen, et al., Household Food Security in the United States in 2012, Economic Research Report No. 155 (Sept. 2013); Food Res. & Action Ctr., Food Hardship in America 2012 (Feb. 2013).

[5] S. Syed, B. Gerber, L. Sharp. "Traveling Towards Disease: Transportation Barriers to Health Care Access." Journal of Community Health. October, 2013.

[6] H. Resnick, R. Acierno, D. Kilpatrick. "Health Impact of Interpersonal Violence: Medical and Mental Health Outcomes." Journal of Behavioral Medicine, 1997.

[7] V. Felitti, et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults—The Adverse Childhood Experiences Study." American Journal of Preventive Medicine. May 1998.

[8] B. C. Booske, J. K. Athens, D. A. Kindig et al., Different Perspectives for Assigning Weights to Determinants of Health (University of Wisconsin Population Health Institute, Feb. 2010).

[9] L. M. Gottlieb, A. Quiñones-Rivera, R. Manchanda et al., "States' Influences on Medicaid Investments to Address Patients' Social Needs," American Journal of Preventive Medicine, Jan. 2017 52(1):31–37.

Recognizing that North Carolina is breaking new ground with the Pilots, the Department of Health and Human Services ("the Department") will rigorously evaluate the Pilots to assess their effectiveness and identify key elements, including successful services, that could be continued on an ongoing basis and extended statewide in the Medicaid program.

The Pilots will operate in three regions of the state – two in eastern North Carolina and one in western North Carolina. See Appendix A for a map of the Pilot regions. An organization in each region – called the "Healthy Opportunities Network Lead" – will build and oversee networks of HSOs that will deliver Pilot services. The Pilots are expected to serve a monthly average of 13,000 - 20,000 enrollees once the program is fully ramped up, the majority of whom will be Standard Plan members.

The purpose of this document is to provide guidance to Advanced Medical Home (AMH) Tier 3 practices on how they can participate in the Pilots. The sections below detail the specific roles and responsibilities for AMH Tier 3 practices as it relates to Pilot care management. AMH Tier 3 Practices serving as a Designated Pilot Care Management Entity[10] must contract with PHPs for the provision of Pilot-related care management to Pilot enrollees. As this is a pilot program, the Department will continually review and update entity requirements based on the on the ground experience of Designated Pilot Care Management Entity.

Section II: Summary of Roles and Responsibilities for Pilots

Foundational to North Carolina's Medicaid managed care program, which includes both Standard Plans and Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans), is local care management integrated with primary care where personal interaction is possible. North Carolina's Standard Plans, which launched on July 1, 2021, are required to contract with local care management entities including AMH Tier 3 practices that provide care management for physical health, behavioral health, and social needs. AMH Tier 3 practices may fulfill their care management responsibilities with their own staff or by working with a Clinically Integrated Network (CIN)/Other Partner. If a qualifying enrollee does not receive care management from an AMH Tier 3 or CIN/Other Partner, Standard Plans must directly provide care management services.[11]

Mirroring the Department's approach to care management for all Medicaid managed care enrollees, it is also critical to the Pilot program that Pilot care management—which is offered in addition to the broader care management responsibilities under North Carolina's Medicaid managed care program[12] — is delivered by designated local care management entities (or by PHPs if enrollees do not receive care management from a designated local care management entity). Pilot care management services, which build on existing care management requirements, include assessing patients' Pilot eligibility and specific non-medical needs, and connecting them to appropriate Pilot services. Recognizing the added responsibilities that come with Pilot participation, AMH Tier 3 Practices serving as a Designated Pilot Care Management Entity or their delegated CIN/Other Partner will receive an additional, DHHS-standardized, Pilot Care Management per member per month (PMPM) payment, on top of existing care management and medical home payments, for each Medicaid enrollee assigned to a Pilot-participating Tier 3 AMH regardless of Pilot enrollment at Pilot launch (discussed more in Section V: AMH Tier 3 Payment for Pilot Responsibilities).

[10] A Designated Care Management Entity that is assuming care management responsibilities specifically related to the Healthy Opportunities Pilot.

[11] BH I/DD Tailored Plans are planning to launch in July 2022. While BH I/DD Tailored Plans are not the focus for this guidance, it is anticipated that many of the requirements in this document will apply.

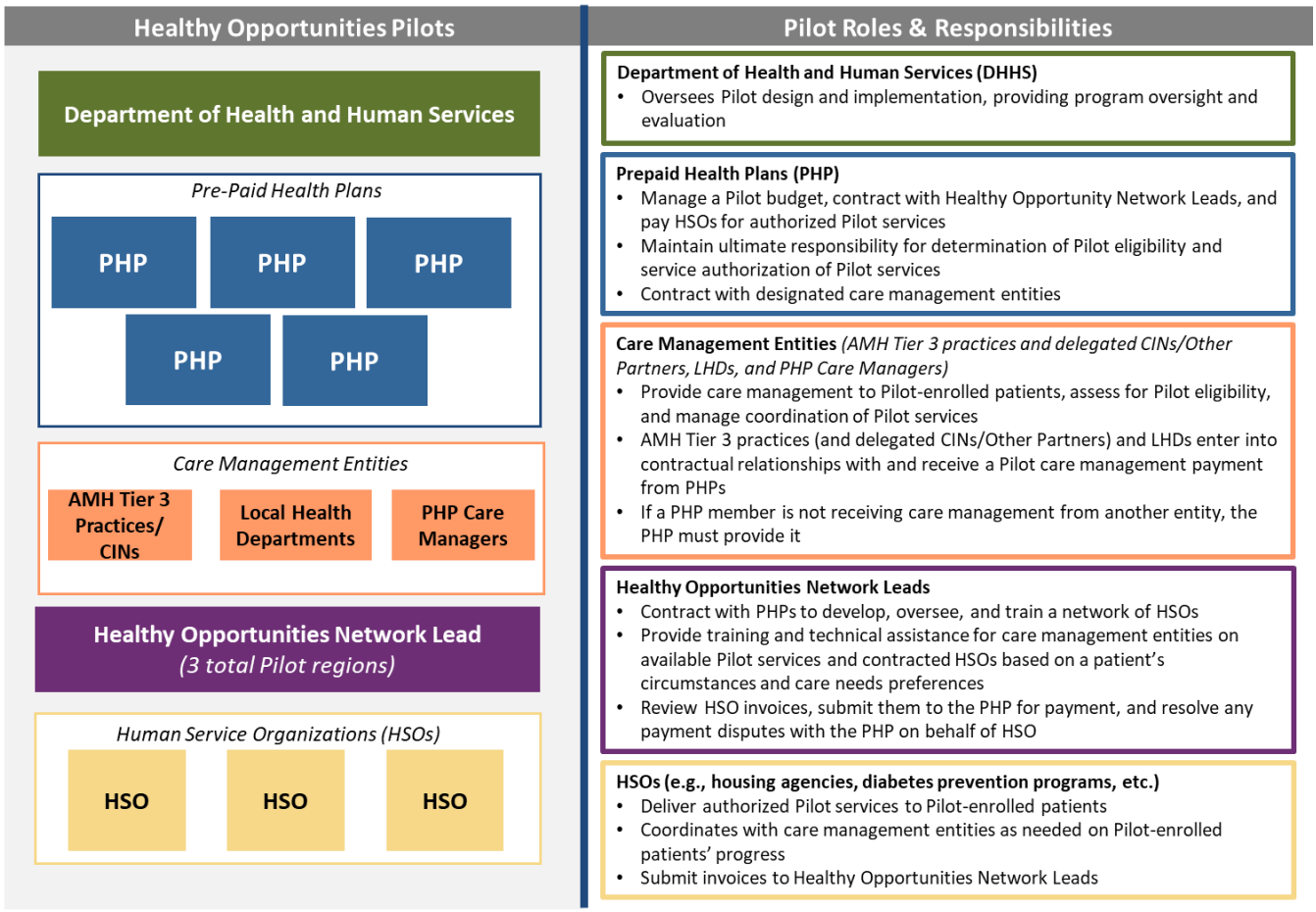
[12] For a complete list of AMH Tier 3 care management responsibilities, refer to the AMH Provider Manual 2.0.

A critical component of implementing the Pilots is how PHPs and local care management entities will work together to identify and enroll patients who are eligible for Pilot services, connect those individuals to such services, and ensure ongoing whole person care management. The Department has developed the following overarching goals for these processes:

- Place Medicaid patients at the center of the Pilot program, prioritizing the patient's seamless and timely experience;
- Utilize a "no wrong door" policy to streamline enrollment into the Pilot program regardless of where a patient initially seeks care;
- Encourage that care management for the Pilot program occurs at the local community level;
- Standardize information collected regarding patients' Pilot eligibility and recommended Pilot services using a standard documentation tool called the Pilot Eligibility and Service Assessment (PESA);
- Seek to ensure services are allocated across all Pilot-eligible patient populations;
- Minimize the number of patient handoffs between PHPs and care management entities;
- Standardize the processes and systems as much as possible across PHPs to eliminate care management entity and HSO burden; and
- Maintain accountability and integrity for the Pilot program.

Figure 1 describes the key roles and responsibilities for each Pilot entity and provides an overview of how the entities interact with one another.

Figure 1: Key Roles and Responsibilities for Pilot Entities



This document provides specific guidance for how AMH Tier 3 practices, CINs/Other Partners (including Local Health Departments that are also certified as AMH Tier 3 practices) can participate in the Pilots. PHPs will not receive Pilot care management payments but will be required to provide the same core Pilot care management functions that designated care management entities provide.

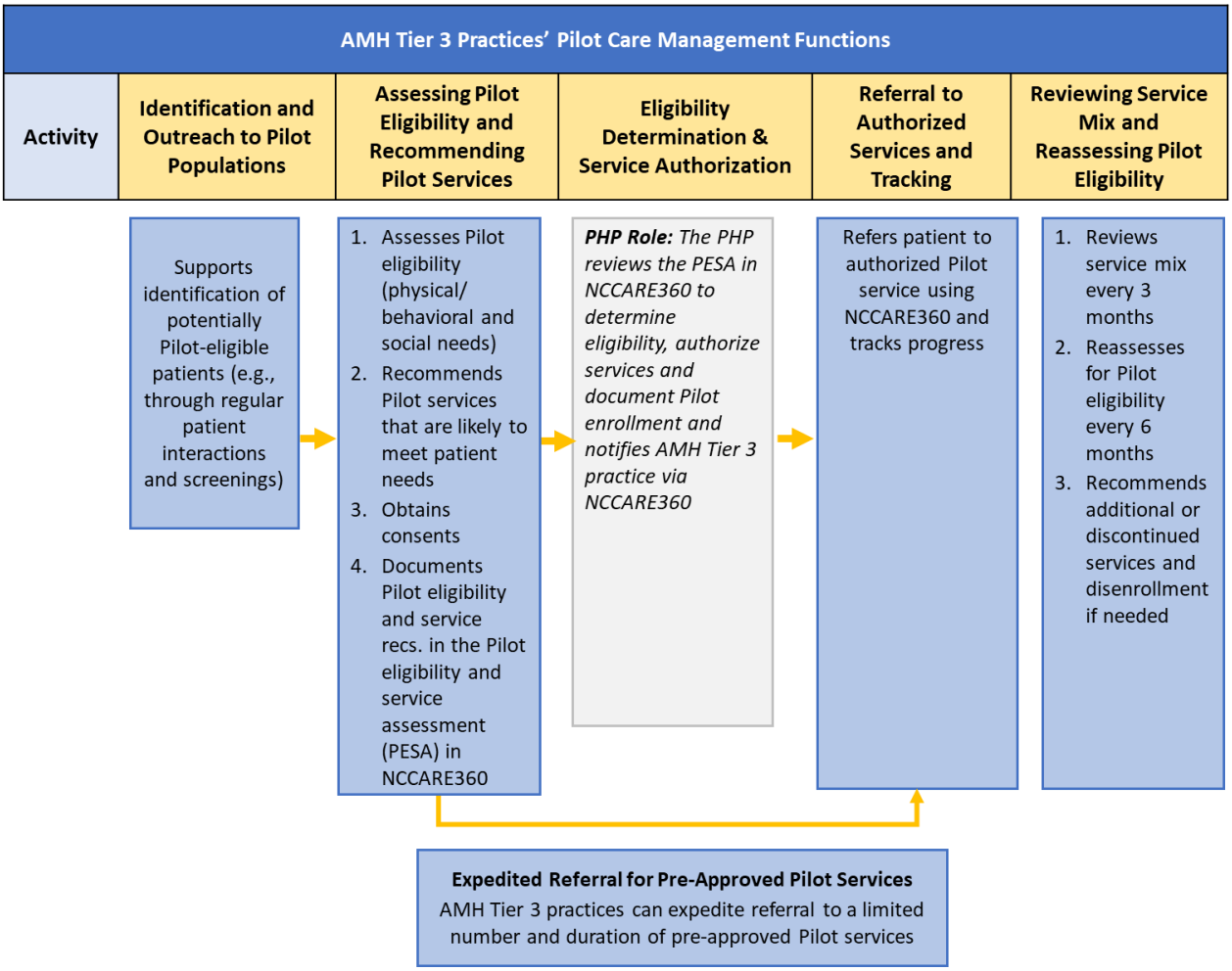
Section III, below, further defines Pilot care management responsibilities.

Section III: Pilot Care Management Responsibilities for AMH Tier 3 Practices Serving as a Designated Pilot Care Management Entity

Participating in the Pilots gives AMH Tier 3 practices the opportunity to be part of an innovative and nationally recognized initiative that will shape North Carolina's Medicaid program. Participating AMH Tier 3 practices will integrate their Pilot responsibilities into clinical care, further supporting the vision of whole-person care. The cornerstone of the AMH Tier 3 program is that care management is delivered to patients locally, and the same is true for the Pilots. While the Department strongly encourages AMH Tier 3 practices to participate in the Pilots, participation is not required. AMH Tier 3 practices that choose to participate in the Pilots are responsible for ensuring Pilot care management is provided to their patients; they may fulfill this responsibility with their own staff or by working with a CIN/Other Partner. In alignment with current AMH contracting for care management with PHPs, each AMH Tier 3 must have a contract with the PHP for pilot-related care management activities. Contracting should follow current arrangements (e.g., if a PHP contracts directly with a CIN/Other Partner for care management, rather than through an AMH Tier 3 practice).

Figure 2 outlines the critical Pilot care management functions that AMH Tier 3 practices will perform to participate in the Pilots and receive Pilot care management payments.

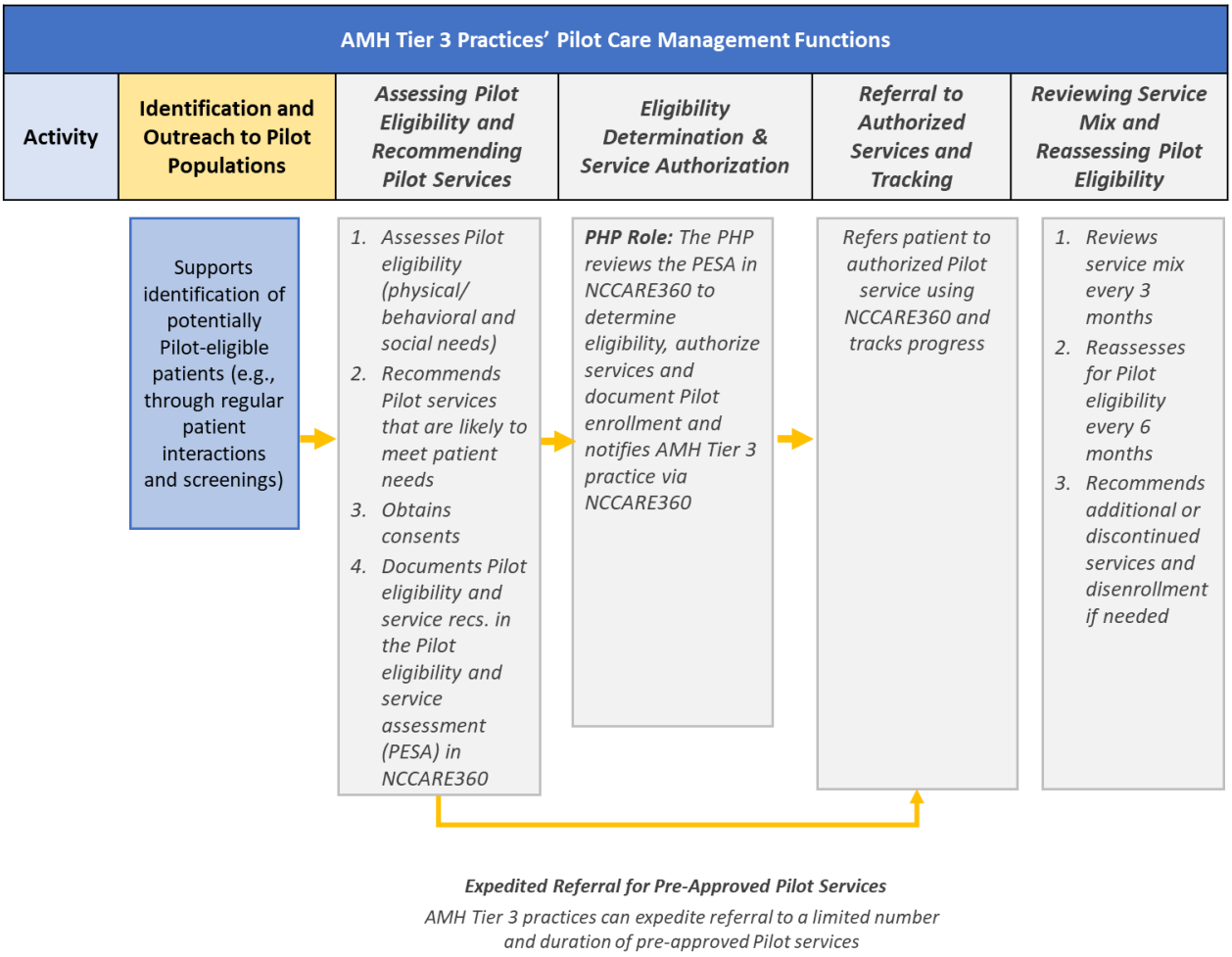
Figure 2: AMH Tier 3 Practices' Pilot Care Management Functions



Getting patients initially enrolled in the Pilots and connected to Pilot services will require a higher level of effort. Once patients are enrolled in the Pilots, AMH Tier 3 practices will have a minimum requirement of engaging with their Pilot-enrolled patients every three months to review their Pilot services (described in more detail below); some Pilot-enrolled patients will require more frequent and intensive engagement and coordination.

The below sub-sections discuss each care management activity in the graphic in greater detail.

Identification and Outreach to Pilot Populations



AMH Tier 3 practices should build in opportunities to identify potentially Pilot-eligible patients during existing touchpoints with members who have been identified for care management and/or referred by the PHP or are currently receiving comprehensive care management. These touchpoints may occur during regular care visits, care manager check-ins, throughout pregnancy and the postpartum period, at transitions of care, and when a patient's circumstances or needs change significantly (e.g., a patient has been diagnosed with a chronic condition).

During these existing touchpoints, AMH Tier 3 practices can utilize the DHHS standardized Healthy Opportunities screening questions or other SDOH screening tools approved by the Department, annual Comprehensive Assessments, and any data analytics used by the practice for existing care management to help identify patients that may potentially be eligible for the Pilot. (Eligibility criteria for the Pilot is outlined in the next section.)

AMH Tier 3 practices must also conduct outreach to any of their patients that PHPs, providers, or HSOs flag as being potentially Pilot eligible. At least quarterly, PHPs will identify patients they think may be eligible for the Pilots based on PHP data. Once identified, the PHPs will notify each patient's AMH Tier 3 practice/CIN Other Partner as part of the patient risk list transfer if the patient already has an assigned AMH Tier 3 practice. If the PHP identifies a potentially eligible patient who is not currently assigned to an AMH Tier 3

practice, the PHP will assign the patient to an AMH Tier 3 practice or Local Health Department (as appropriate) within 10 business days. If the patient is already assigned to an AMH Tier 1 or Tier 2 practice, the PHP will assume Pilot-related care management. Upon being notified by the PHP, AMH Tier 3 practices should conduct outreach – including at least two documented follow-up attempts if the first is unsuccessful - to the patient within three business days to assess for Pilot eligibility**.** Providers and HSOs may also flag patients they think may be eligible for the Pilots, and patients (or their family members) may identify themselves as possibly Pilot eligible. If the provider, HSO, or patient knows who the patient's assigned AMH Tier 3 practice is, they may notify the AMH Tier 3 practice, and upon being notified, the AMH Tier 3 practice should conduct outreach, including two follow-up attempts, to the patient within three business days to assess for Pilot eligibility. If the patient's assigned AMH Tier 3 practice is not known to the provider, HSO, or patient, they may notify the member's PHP in order to flag a potentially Pilot eligible patient has been identified and should be assessed for Pilot eligibility and recommended services. The PHP will notify the AMH Tier 3 practice, if applicable, to conduct an assessment of Pilot eligibility and recommend appropriate services. Once an AMH Tier 3 practice has conducted outreach to a patient, the AMH Tier 3 practice should document this outreach in the patient's Care Plan or in the patient record, as appropriate based on whether the member has an existing Care Plan, and inform the PHP, provider, or HSO of the outcome of the outreach through existing communication channels.

Assessing Pilot Eligibility and Recommending Pilot Services

AMH Tier 3 Practices' Pilot Care Management Functions					
Activity	***Identification and Outreach to Pilot Populations***	**Assessing Pilot Eligibility and Recommending Pilot Services**	***Eligibility Determination & Service Authorization***	***Referral to Authorized Services and Tracking***	***Reviewing Service Mix and Reassessing Pilot Eligibility***
	Supports identification of potentially Pilot-eligible patients (e.g., through regular patient interactions and screenings)	1. Assesses Pilot eligibility (physical/ behavioral and social needs) 2. Recommends Pilot services that are likely to meet patient needs 3. Obtains consents 4. Documents Pilot eligibility and service recs. in the Pilot eligibility and service assessment (PESA) in NCCARE360	***PHP Role:*** *The PHP reviews the PESA in NCCARE360 to determine eligibility, authorize services and document Pilot enrollment and notifies AMH Tier 3 practice via NCCARE360*	*Refers patient to authorized Pilot service using NCCARE360 and tracks progress*	1. *Reviews service mix every 3 months* 2. *Reassesses for Pilot eligibility every 6 months* 3. *Recommends additional or discontinued services and disenrollment if needed*

Expedited Referral for Pre-Approved Pilot Services

AMH Tier 3 practices can expedite referral to a limited number and duration of pre-approved Pilot services

B1. Assessing Pilot Eligibility: **To assess a patient's eligibility for the Pilots, AMH Tier 3 practices need to confirm and document in the Pilot eligibility and service assessment (PESA) in NCCARE360 whether the patient:**

- Lives in a Pilot region;
- Is enrolled in Medicaid managed care;
- Meets at least one qualified physical/behavioral health criterion; and
- Has at least one qualified social risk factor.

Pilot eligibility is determined based on whether the member lives in a Pilot region, not on the location of the AMH Tier 3 practice where a member receives care. Table 1 outlines the detailed physical/behavioral qualifying conditions for the Pilot program, and Table 2 outlines qualifying social risk factors for the Pilot program.

Table 1: Pilot Physical/Behavioral Health-Based Criteria

Population	Age	Physical/Behavioral Health-Based Criteria (must meet at least one criteria)
Adults	**21+**	• 2 or more chronic conditions. Chronic conditions that qualify an individual for Pilot program enrollment include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine and cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease and chronic renal failure, in accordance with Social Security Act section 1945(h)(2). • Repeated incidents of emergency department use (defined as more than four visits of either per year) or hospital admissions.
Pregnant Women	**N/A**	• Multifetal gestation • Chronic condition likely to complicate pregnancy, including hypertension and mental illness • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescent ≤ 15 years of age • Advanced maternal age, ≥ 40 years of age • Less than one year since last delivery • History of poor birth outcome including: preterm birth, low birth weight, fetal death, neonatal death
Children	**0-3**	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit

	0-20	• One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of <5th or >85th %ile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention deficit/hyperactivity disorder, and learning disorders • Experiencing three or more adverse childhood experiences (ACEs), or traumatic events that occur to a child before the age of 18. Examples of ACEs include a child that experiences, child abuse or neglect, substance abuse in the household, parental violence, or criminal behavior in the household. AMH Tier 3 practices may use ACEs screening tools or an "ACEs Score" to identify ACEs. • Enrolled in North Carolina's foster care or kinship placement system

Table 2: Pilot Social Risk Factors

Risk Factor	Definition
Homelessness and Housing Insecurity	• Individuals who are **homeless**: defined as an individual who lacks housing, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.[13] • Individuals who are **housing insecure:** including individuals who, within the past 12 months, have ever stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch surfing); are worried about losing their housing; or within the past 12 months have been unable to get utilities (heat, electricity) when it was really needed.[14]
Food Insecurity	Patients who are experiencing food insecurity—defined as the disruption of food intake or eating patterns because of lack of money and other resources--including those who:[15]

[13] https://www.law.cornell.edu/uscode/text/42/254b

[14] NC DHHS Healthy Opportunities Standardized Screening Questions. Available: https://www.ncdhhs.gov/screening-tool-english-providers-final/download

[15] National Research Council. (2006). Food Insecurity and Hunger in the United States: An Assessment of the Measure. Panel to Review the U.S. Department of Agriculture's Measurement of Food Insecurity and Hunger, Gooloo S. Wunderlich and Janet L. Norwood, Editors, Committee on National Statistics, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press. Available: https://www.nap.edu/download/11578

	• Report reduced quality, variety, or desirability of diet. There may be little or no indication of reduced food intake. This is considered low food security.[16] • Report multiple indications of disrupted eating patterns and reduced food intake. This is considered very low food security.[17] • Report that within the past 12 months they worried that their food would run out before they got money to buy more.[18] • Report that within the past 12 months the food they bought did just not last and they didn't have money to get more.[19]
Transportation Insecurity	Patients for whom, within the past 12 months, a lack of transportation has kept them from medical appointments or from doing things needed for daily living.[20]
At risk of, witnessing, or experiencing interpersonal violence	Patients who report that they feel physically or emotionally unsafe where they currently live; within the past 12 months have been hit, slapped, kicked or otherwise physically hurt by anyone; or within the past 12 months have been humiliated or emotionally abused by anyone.[21]

To assess whether a patient meets the Pilot eligibility criteria, AMH Tier 3 practices should ask the patient questions and review available data/information (e.g., information provided by a PHP on a patient's clinical conditions and/or the patient's results of the DHHS standardized set of Healthy Opportunities screening questions). PHPs have primary responsibility to screen members for unmet health-related resource needs as part of the Care Needs Screening. If a PHP has not already completed the DHHS standardized set of Healthy Opportunities screening questions for the patient, AMH Tier 3 practices should conduct this screening as part of the Pilot eligibility assessment.

B2. Recommending Pilot Services: **After assessing a patient's eligibility for the Pilots, AMH Tier 3 practices should recommend which specific Pilot service(s) would best address the patient's physical/behavioral health and social needs from a list of federally-approved services outlined in Table 3.** Pilot services fall into one of four priority domains: housing, food, transportation, and interpersonal safety/toxic stress. In some cases, a patient may require more than one service—either in one domain (e.g., a patient requires two housing services) or spanning multiple domains (e.g., a patient who requires a food and transportation service).

[16] *Ibid*
[17] *Ibid*
[18] NC DHHS Healthy Opportunities Standardized Screening Questions. Available: https://www.ncdhhs.gov/screening-tool-english-providers-final/download
[19] NC DHHS Healthy Opportunities Standardized Screening Questions. Available: https://www.ncdhhs.gov/screening-tool-english-providers-final/download
[20] *Ibid*
[21] *Ibid*

Table 3: Healthy Opportunities Pilots Services

Pilot Services
Housing
Housing Navigation, Support and Sustaining Services
Inspection for Housing Safety and Quality
Housing Move-In Support
Essential Utility Set-Up
Home Remediation Services
Home Accessibility and Safety Modifications
Healthy Home Goods
One-Time Payment for Security Deposit and First Month's Rent
Short-Term Post Hospitalization Housing
Interpersonal Violence / Toxic Stress
IPV Case Management Services
Violence Intervention Services
Evidence-Based Parenting Curriculum
Home Visiting Services
Dyadic Therapy
Food
Food and Nutrition Access Case Management Services
Evidence-Based Group Nutrition Class
Diabetes Prevention Program
Fruit and Vegetable Prescription
Healthy Food Box (For Pick-Up)
Healthy Food Box (Delivered)
Healthy Meal (For Pick-Up)
Healthy Meal (Home Delivered)
Medically Tailored Home Delivered Meal
Transportation
Reimbursement for Health-Related Public Transportation
Reimbursement for Health-Related Private Transportation
Transportation PMPM Add-On for Case Management Services
Cross-Domain
Holistic High Intensity Enhanced Case Management
Medical Respite
Linkages to Health-Related Legal Supports

As outlined in the federally-approved Healthy Opportunities Pilot Service Fee Schedule (see Appendix B), each Pilot service has a specific unit of service, service rate, service description, anticipated frequency, duration, setting of service delivery, and minimum eligibility criteria for receiving the specific service.

AMH Tier 3 practices will be able to access the eligibility criteria for the Pilots and specific Pilot services in the state-standardized tool called the "Pilot Eligibility and Service Assessment," or the "PESA" (described in more detail below), available on the NCCARE360 platform.

For example, in order to be considered eligible to receive the Diabetes Prevention Program Pilot service, patients must meet the following additional service-specific eligibility criteria:

- Be 18 years of age or older,
- Have a BMI ≥ 25,
- Not be pregnant at the time of enrollment
- Not have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment
- Have one of the following:
  - A blood test result in the prediabetes range within the past year, or
  - A previous clinical diagnosis of gestational diabetes, or,
  - A screening result of high risk for type 2 diabetes through the "Prediabetes Risk Test"[22]

To determine if a patient meets the service-specific eligibility criteria for the particular Pilot service they are recommending for the patient (see Appendix B), AMH Tier 3 practices will need to ask the patient questions and gather and review available data/information to evaluate whether the patient is qualified to receive the service, and document that service in the Pilot eligibility and services assessment (PESA).

AMH Tier 3 practices should also talk to the patient about where and how they would like to receive a Pilot service. For example, the patient might already have a relationship with an HSO that offers the service or only be able to use an HSO that offers evening hours. AMH Tier 3 practices will be able to see all Pilot-participating HSOs in the NCCARE360 platform.

B3. Obtaining Pilot Consents: Patients must give consent to participate in the Pilots. **AMH Tier 3 practices will be responsible for obtaining patient consent for the following activities:**

- **Participation in the Pilots and receipt of Pilot services,** including an understanding that Pilot services are not an entitlement and may be revoked at any time;
- **Sharing of personal data, including personal health information**, that will be used to **evaluate the Pilots** as part of North Carolina's 1115 waiver evaluation; and
- **Sharing of personal data, including personal health information, with organizations in the NCCARE360 network,** that will be stored and exchanged on NCCARE360**.**

To streamline the experience for patients and AMH Tier 3 practices, the Department is working on developing a standardized universal consent form that addresses all required consents listed above. Consent should be recorded in NCCARE360.

AMH Tier 3 practices are permitted to accept electronic or written consent from a patient. Written consents should be stored by attaching them to the patient's PESA in NCCARE360 (described in more detail below). AMH Tier 3 practices must also give an electronic or hard copy of the consent to the patient, if requested by the patient. Consent must be obtained before a PHP authorizes Pilot services or referrals are made to HSOs.

[22] Available at: https://www.cdc.gov/prediabetes/takethetest/

If a patient does not give consent, AMH Tier 3 practices should explain to the patient that he or she will not have Pilot services reimbursed by Medicaid. However, the patient will continue to receive non-Pilot care management to find other non-medical services that meet the member's need. If a patient revokes consent, consent is revoked going forward, and the patient must be disenrolled from Pilot services (see Section F2. Disenrollment from the Pilots).

B4. Documentation Requirements: **AMH Tier 3 practices must document the results of the Pilot eligibility assessment, the specific Pilot service recommendations, the results of the Pilot service-specific eligibility assessment, and the patient's Pilot consents in NCCARE360 for the patient's PHP.** Ultimately, it is the PHP – rather than the AMH Tier 3 practice – that determines whether a patient is eligible for the Pilots and authorized to receive specific Pilot services.

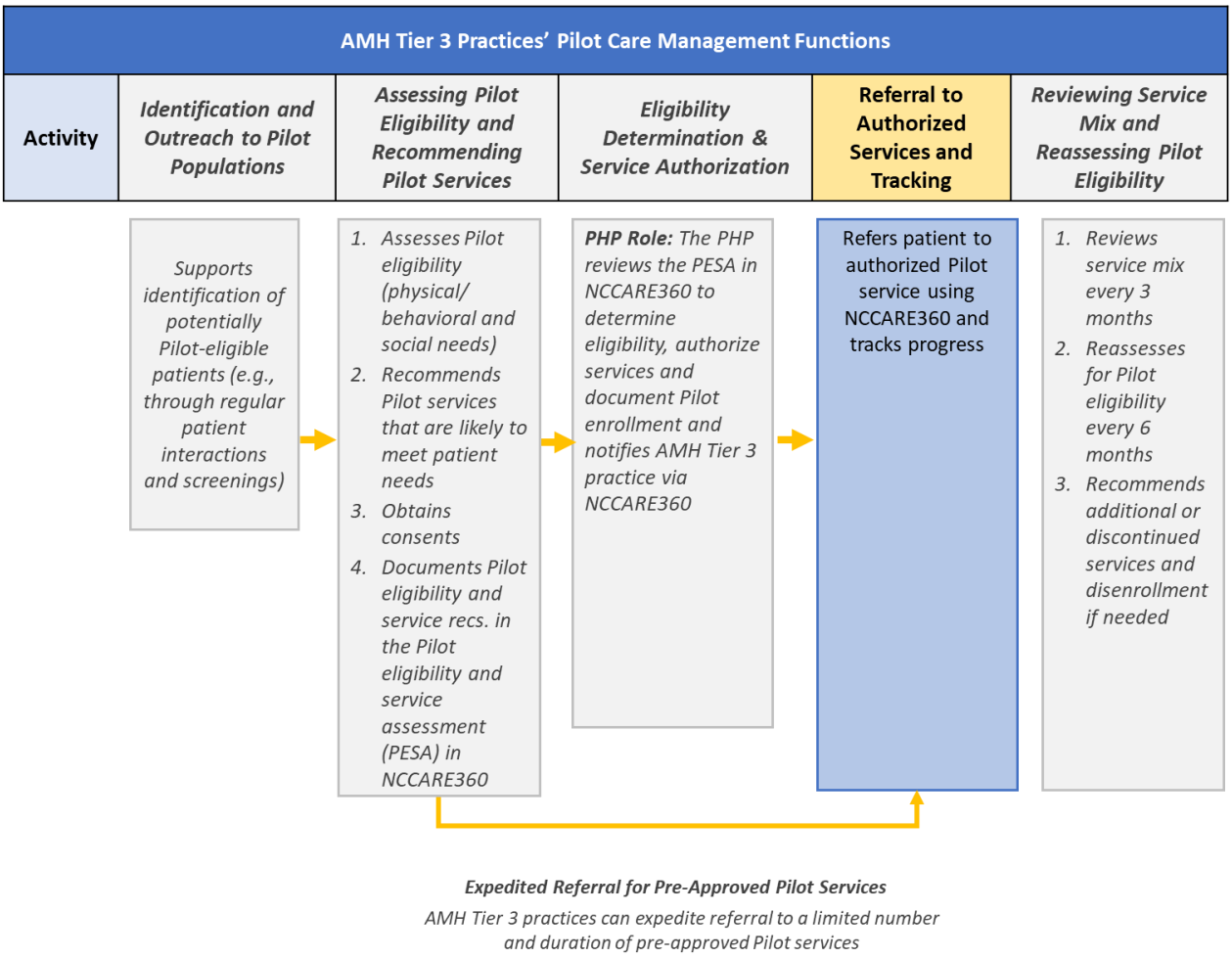
AMH Tier 3 practices will document this information for the PHP in a standardized tool called the PESA on the NCCARE360 platform. All Pilot-enrolled patients receiving services must have a completed and up-to-date PESA documenting their Pilot eligibility criteria as well as eligibility criteria for each Pilot service being requested.

AMH Tier 3 practices will utilize NCCARE360 to transmit the completed PESA including the enrollment and authorization request to the patient's PHP that documents the following for service authorization**:**

- Patient contact information (including address to ensure they live in a Pilot region);
- Care manager of record;
- Physical and social risk factors supporting Pilot eligibility;
- Recommended Pilot services;
- Service-specific eligibility criteria for recommended services;
- Indication of consent for 1) Pilot participation, 2) Pilot evaluation and 3) validation of consent to share personal information using NCCARE360; and
- Additional rationale or documentation for specific services (as needed).

AMH Tier 3 practices are responsible for completing the PESA during the initial Pilot assessment and updating it any time there is a change to a patient's service needs or Pilot eligibility. If the PHP requires additional eligibility information (e.g., if information in the PESA is missing or incomplete), the PHP may contact the AMH Tier 3 practice to obtain it. AMH Tier 3 practices should work collaboratively with PHPs to fill out any incomplete information. PHPs will not be permitted to require AMH Tier 3 practices to submit anything beyond what is required to determine Pilot eligibility and authorize appropriate services, and only PHPs and AMH Tier 3 practices will be able to view and make changes to a patient's PESA.
PHPs will be subject to standardized turnaround times for authorizing Pilot services (that vary by service). PHPs will document their decision and rationale on Pilot eligibility and service authorization in a patient's PESA and notify the AMH Tier 3 practice of its decision. At Pilot launch, these notifications will occur outside of NCCARE360, but over time the Department intends to integrate them into NCCARE360. For a limited number of low-cost, high-value services, AMH Tier 3 practices will be permitted to refer patients to 30 days' worth of Pilot services without prior approval from PHPs (see Section D: Expedited Referrals for Pre-Approved Pilot Services)

Referral to Authorized Pilot Services and Tracking



C1. Making Referrals to Pilot Services: **AMH Tier 3 practices are responsible for referring eligible patients to an appropriate HSO through the NCCARE360 platform. Once a PHP has authorized a Pilot service for a patient, the AMH Tier 3 practice must submit an electronic referral for the service in NCCARE360 within two business days of receiving PHP authorization.** PHPs will monitor receipt of invoices from HSOs to ensure that referrals are occurring and services are being delivered in a timely manner. NCCARE360 will clearly indicate which HSOs are participating in the Pilots. Upon PHP notification of service authorization, the AMH Tier 3 practice must communicate to the patient the authorized Pilot services and that an HSO will soon be reaching out to them.

AMH Tier 3 practices may target a referral to particular HSO (for example, if a patient has an existing relationship with that HSO) or send the referral to all relevant HSOs that are available to provide the Pilot service. NCCARE360 will have a profile of the HSO including but not limited to: contact information, hours of operation, services offered, and languages spoken. AMH Tier 3 practices may also consult with the Healthy Opportunities Network Lead as needed to assist in identifying appropriate HSOs.

Referrals for services that require simultaneous case management will be noted in the PESA, in NCCARE360(e.g., in order to receive the "one-time payment for security deposit and first month's rent"

service, a patient must also receive ongoing housing case management) and will include a separate referral to an HSO case management service if the patient does not already have an established HSO case management service. For a list of Pilot services that require simultaneous case management, see Healthy Opportunities Pilot Service Fee Schedule in Appendix B.

C2. Tracking Referral Status and Outcomes: **Once a referral is sent, AMH Tier 3 practices should follow-up with the HSO if the referral is not accepted within two business days of the referral being sent via NCCARE360 and elevate the issue to the appropriate Network Lead as necessary to ensure the individual can access services.** AMH Tier 3 practices should reasonably expect HSOs to accept all appropriate service referrals. In limited circumstances, HSOs may reach capacity for how many individuals they can serve. In such circumstances, HSOs are responsible for proactively notifying their Healthy Opportunity Network Lead of limited capacity and indicating that they are not currently accepting referrals in NCCARE360 in order to prevent further referrals that cannot be acted upon. While AMH Tier 3 practices must ensure HSOs accept individual referrals submitted for their patients in a timely manner, Network Leads will hold primary responsibility for monitoring referral acceptance from HSOs across their network.

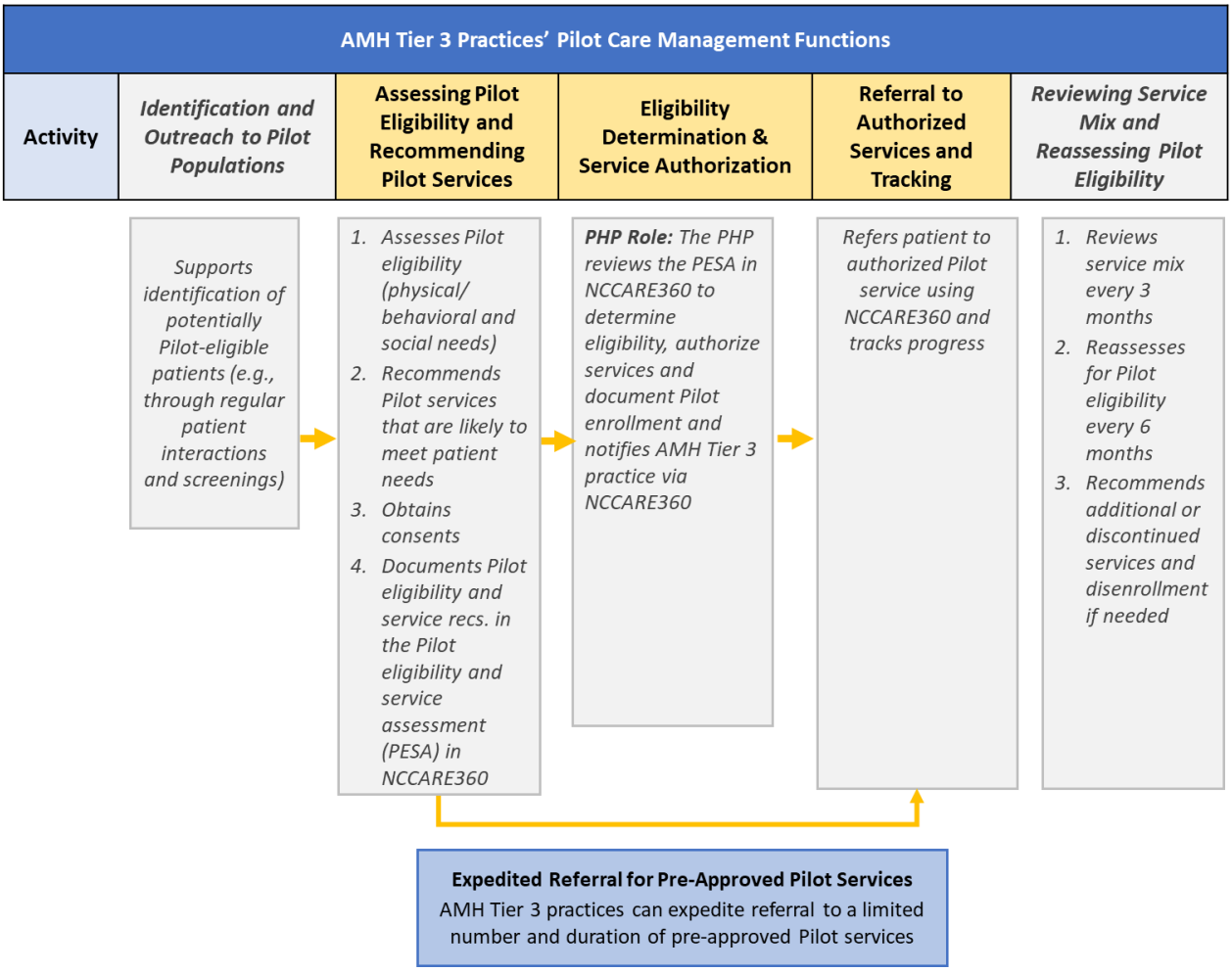
If a referral was sent to a particular HSO and is not accepted within two business days, the AMH Tier 3 practice should contact the HSO to confirm whether it can provide the service. If the HSO does not respond or indicates it does not have capacity, AMH Tier 3 practices should escalate the issue to both the PHP and the NL, as appropriate, and send the referral to another HSO.

Similarly, if a referral was sent to all relevant HSOs and is not accepted within two business days, AMH Tier 3 practices should escalate the issue to both the PHP and the NL, as appropriate. AMH Tier 3 practices then need to monitor and track the Pilot services delivered and coordinate with the HSO to help assess to what extent the Pilot service(s) are meeting their needs.

C3. Documenting Pilot Enrollment Status and Authorized Pilot Services in Patient's Care Plan:
Upon Pilot enrollment, AMH Tier 3 practices must initiate care management to the member, if the member is not already receiving care management and continue providing care management if the member is already receiving it**.**

For Pilot-enrolled patients, AMH Tier 3 practices must include in the patient's Care Plan information on Pilot enrollment status, authorized Pilot services and Pilot-related needs. AMH Tier 3 practices will **regularly update patient's Care Plan** when an HSO accepts a referral for an authorized Pilot service, throughout the time the patient is receiving Pilot services, and after a patient's three-month Pilot service mix review and six-month Pilot eligibility reassessment (discussed more below).

Expedited Referrals for Pre-Approved Pilot Services



In order to expedite service delivery and reduce touchpoints with the patient, PHPs are required to permit AMH Tier 3 practices to refer patients to a select number of high-value, low-cost Pilot services for a 30-day passthrough period without prior PHP approval. PHPs are required to treat these select Pilot services as "pre-approved" for up to 30 days. "Pre-approved" Pilot services will be standardized across all PHPs and include:

- Fruit and Vegetable Prescription
- Healthy Food Box (For Pick-Up)
- Healthy Food Box (Delivered)
- Healthy Meal (For Pick-Up)
- Healthy Meal (Home Delivered)
- Reimbursement for Health-Related Public Transportation
- Reimbursement for Health-Related Private Transportation

The Department may expand this list over time.

After an AMH Tier 3 practice identifies a potentially Pilot-eligible patient that are currently in care management or who have been referred to the AMH for a Pilot assessment, who would benefit from one of the pre-approved services, the AMH Tier 3 practice obtains required consents, validates Pilot eligibility and service-specific eligibility using the PESA in NCCARE360. **The AMH Tier 3 practice may then refer the patient to an HSO that delivers the specific pre-approved Pilot service using NCCARE360 for a period of up to 30 days.** The AMH Tier 3 practice monitors via NCCARE360 that the referral is accepted by an HSO within two business days and then creates or updates the patient's Care Plan with the pre-approved Pilot service. The AMH Tier 3 practice tracks the pre-approved Pilot service delivered to the patient and coordinates with the HSO to track patient progress.

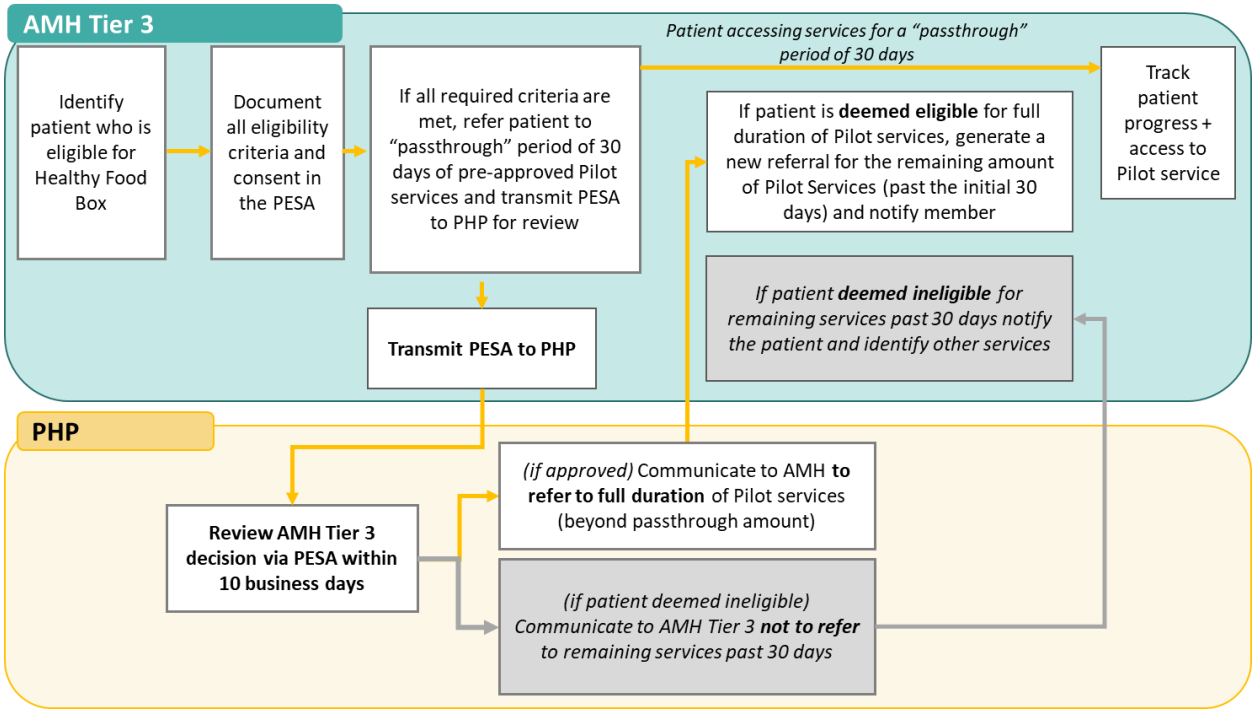
At the same time that it submits an electronic referral on NCCARE360 for a pre-approved service, the AMH Tier 3 practice must alert the patient's PHP by sending the completed PESA in NCCARE360. The PESA will include a recommendation for the proposed duration of the service (which may exceed the initial 30-day period) and the patient will be provisionally enrolled in the Pilots and pre-authorized to receive a Pilot service for a period of up to 30 days. The PHP will then review the PESA to assess the patient's eligibility for the Pilots and the selected service beyond the first 30 days.

If the PHP deems the patient eligible for additional services beyond the 30-day passthrough period, the PHP will alert the AMH Tier 3 practice, which then must generate a new referral to the same HSO to extend the Pilot services beyond the initial 30 days. The AMH Tier 3 practice must then communicate to the patient that they are authorized to receive the full duration of the Pilot service and monitors that the HSO accepts the new referral within two business days. The AMH Tier 3 practice will also update the patient's Care Plan, track the additional Pilot services delivered to the patient, and coordinate with the HSO regarding patient progress.

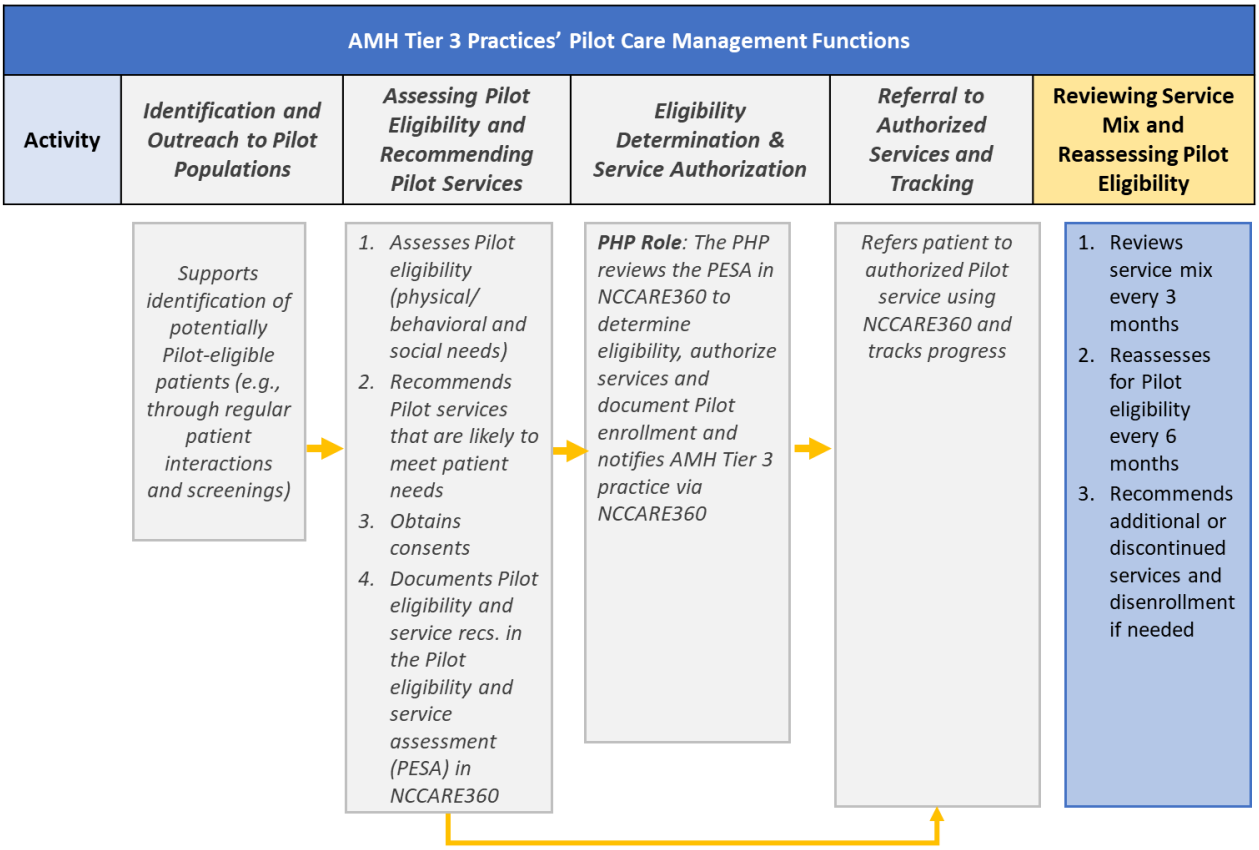
If the PHP deems the patient ineligible for the Pilots or the full duration of the recommended service, the PHP will alert the AMH Tier 3 practice of its decision. The AMH Tier 3 practice then may not issue another referral for the patient for the recommended Pilot service. The AMH Tier 3 practice must communicate to the patient of the PHP's decision and direct the patient to other non-Pilot services and HSOs to meet their needs.

PHPs have the ability to discontinue an individual AMH Tier 3 practice's ability to refer patients to pre-approved services if that practice is found to have a pattern of making expedited referrals for patients that are subsequently found to be ineligible for the Pilots or if the PHP runs out of Pilot funds.
Note: the practice should receive prior notification that they are outliers in referring ineligible members to the program and given a time period to demonstrate improvement.

Figure 3: Expedited Referrals for Pre-Approved Pilot Services



Reviewing Pilot Service Mix and Reassessing Pilot Eligibility



The Pilot program requires AMH Tier 3 practices to conduct a three-month assessment of a patient's Pilot service mix to determine if the authorized Pilot services are meeting a patient's needs. If not, the AMH Tier 3 practice should modify the existing service mix, recommend to the PHP adding new services, and/or discontinue one or more services. **Pilot-enrolled patients must also have a six-month assessment where they are Pilot eligibility (eligibility reassessment) based on the qualifying criteria (physical/behavioral health criteria and social risk factor) in addition to the service mix review.** Reassessment at the three- and six-month intervals after enrollment are the minimum requirements for patient contact but should not replace regular care team check-ins with patients to understand how Pilot services are meeting the patient's needs. If an AMH Tier 3 practice identifies that a Pilot-enrolled patient has met their Care Plan goals in less than 3 months and no longer requires Pilot services, the AMH Tier 3 practice may recommend discontinuing Pilot services (see Section F1. Discontinuation of Pilot Services).

AMH Tier 3 practices must identify patients requiring a three-month assessment (service mix review) and six-month assessment (Pilot eligibility reassessment), and identify patients that are due for a three- or six-month assessment based on their date of enrollment (i.e., not from when the patient accessed the Pilot service to which they were referred). AMH Tier 3 practices will schedule an in-person, telephonic, or video reassessment with (depending on the practice's chosen modality and enrollee preference). AMH Tier 3 practices should then schedule a reassessment meeting with Pilot-enrolled patients within 30 days. AMH Tier 3 practices should make reassessment attempts at least monthly following the original due date of a three- or

six-month assessment. If the patient does not respond by the next six-month interval, AMH Tier 3 practices must recommend to the PHP that the patient be disenrolled from the Pilots (described in detail below).

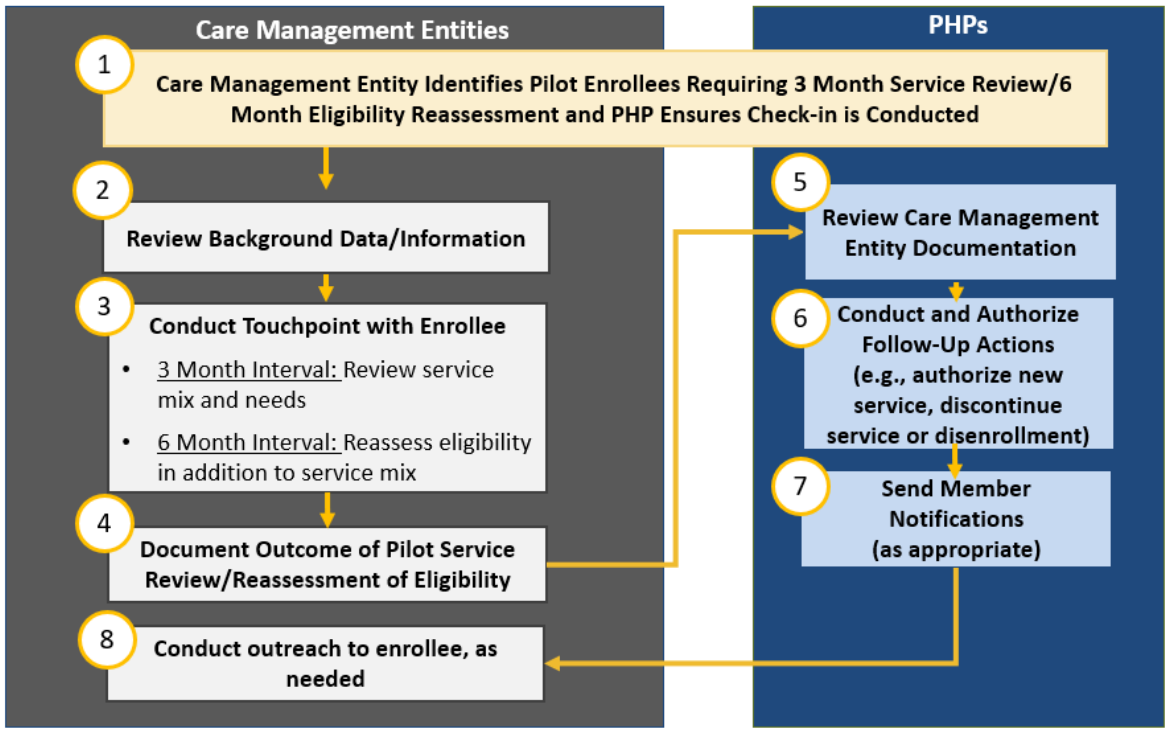
Prior to conducting the three- or six-month assessment, AMH Tier 3 practices should review all available data on the patient in preparation for the assessment, including, for example:

- The patient's Care Plan, including current and previously authorized Pilot services, status updates and overarching goals;
- Care team notes from prior assessments;
- Outcomes of referred Pilot services in NCCARE360 and any subsequent information provided by HSO staff to the care team; and,
- Data provided by the PHP related to health care activities.

PHPs will monitor requirements for Pilot service mix reviews and eligibility reassessment through spot audits of member PESAs, but will not require additional reporting of AMH Tier 3 practices related to reassessments.

Figure 4 provides a summary of the process AMH Tier 3 Practices will use to conduct three-and six-month assessments.

Figure 4: Reviewing Pilot Service Mix and Reassessing Eligibility: High-Level Process Flow

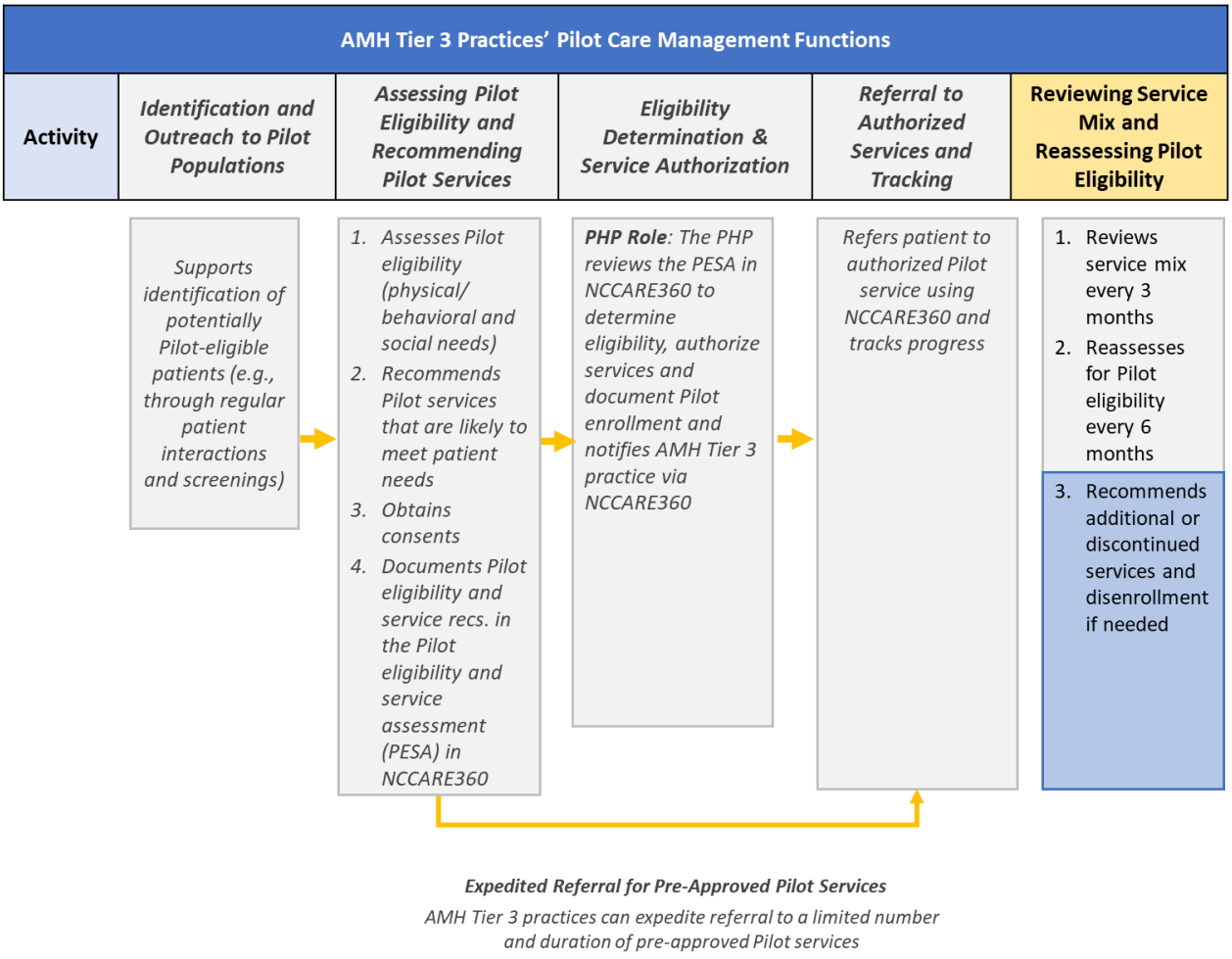


E1. Three-Month Service Mix Review: For each Pilot-enrolled patient, AMH Tier 3 practices must facilitate an assessment every three months to discuss the patient's current service mix and assess if it is meeting the patient's needs. AMH Tier 3 practices should use the Department's standardized Healthy Opportunities screening questions and/or other assessments, including those used to originally recommend Pilot services, to evaluate if the patient needs different Pilot services. The service mix review may occur concurrently with a

Pilot eligibility reassessment if it is being conducted at the six-month interval (described in the next section). If a patient has no new or changed needs and requires Pilot services to continue, AMH Tier 3 practices will document this in the patient's Care Plan. If new or modified services are required due to new or changed needs, AMH Tier 3 practices should use the PESA in NCCARE360 to make recommendations for new or modified services and submit the PESA to the PHP for review and authorization. If AMH Tier 3 practices decide that a service is no longer needed, they are permitted to discontinue that particular service (see next section for additional details). AMH Tier 3 practices should document the outcome of the three-month assessment in the patient's PESA, including any PHP action or decision, and update the patient's Care Plan.

***E2. Six-Month Pilot Eligibility Reassessment*:** In addition to conducting a Pilot service mix review every three months, AMH Tier 3 practices must reassess each Pilot-enrolled patient for their ongoing Pilot eligibility every six months. To do so, AMH Tier 3 practices should ensure that a Pilot-enrolled patient still has a qualifying social factor in one of the priority Healthy Opportunities domains and assess the patient's underlying physical/behavioral health criteria (or new criteria) that makes the patient eligible for the Pilots (e.g., the patient requires ongoing Pilot services to address the needs that make them eligible for the Pilots in the first place). The Pilot eligibility reassessment will always be conducted concurrently with a three-month service mix review. Any changes made to Pilot eligibility should be documented in the PESA and transmitted to the PHP for review. AMH Tier 3 practices should document the outcome of the six-month Pilot eligibility reassessment in the patient's PESA in NCCARE360, including any PHP action or decision, and update the patient's Care Plan. Changes to Pilot eligibility status will automatically impact the patient's ability to receive Pilot services. If the PHP finds the patient ineligible for the Pilots, the patient's Pilot services will be discontinued, and the AMH Tier 3 practice should find new, non-Pilot services that meet that patient's needs.

Discontinuation of Pilot Services and Disenrollment from Pilots



Patients' needs and circumstances will change over the course of their Pilot participation. For this reason, there are some circumstances in which a patient's Pilot services should be discontinued, and other circumstances where the patient should be disenrolled from the Pilots.

F1. Discontinuation of Pilot Services: Discontinuation of Pilot services refers to instances when an authorized Pilot service should be stopped. Discontinuation of a service does not necessarily mean that an individual is ineligible to receive other or modified amounts/intensity of existing Pilot services. Examples of potential scenarios for discontinuation of Pilot services include:

- Current Pilot service(s) are not meeting the needs of the patient (e.g., the patient no longer requires support with their housing needs, but indicates that he hasn't been able to purchase enough food in the past month and may require a Healthy Food Box).
- Patient has met their Care Plan goals and no longer requires the Pilot service (e.g., patient has been stably housed for 12 months and no longer requires Housing Navigation, Support and Sustaining Services).

- Patient no longer meets the service-specific qualifying criteria (e.g., the patient no longer has pre-diabetes and is ineligible for the diabetes prevention program service).

If AMH Tier 3 practices identify that a Pilot service should be discontinued during a three-month assessment, six-month Pilot reassessment, or other regular check-in with a patient, AMH Tier 3 practices should document that the service is to be discontinued and the rationale (e.g., if the service is no longer meeting the member's need) for doing so in a patient's PESA and notify the PHP via NCCARE360. AMH Tier 3 practices must then close out any open referrals for the discontinued service(s) in NCCARE360, communicate directly with the HSO(s) regarding the change in status, and update the patient's Care Plan. After a Pilot service has been discontinued, AMH Tier 3 practices need to communicate the decision to the patient and provide transition support by identifying other Pilot and non-Pilot services and programs to meet the patient's ongoing needs. If the patient requires new or modified Pilot services in lieu of the discontinued service, AMH Tier 3 practices must submit a recommended Pilot service to the PHP as part of the PESA.

F2. Disenrollment from the Pilots: Pilot disenrollment refers to instances where a patient is no longer eligible to participate in the Pilots and should no longer receive Pilot services. Examples of potential scenarios for disenrollment from the Pilots include:

- Patient is no longer enrolled in Managed Care.
- Patient no longer lives in a Pilot region (regardless of the location of the AMH Tier 3 practice where they receive care) .
- Patient is receiving duplicative services or programs that disqualify them from Pilots (e.g., Innovations Waiver services).
- Patient wishes to opt out of the Pilots.
- Patient is unreachable after consistent, monthly outreach efforts by the AMH Tier 3 practice for a period of 6 months.

Upon identifying a trigger for Pilot disenrollment, AMH Tier 3 practices must document information and rationale for Pilot disenrollment in a patient's PESA and transmit to the PHP for verification. If the PHP agrees with the AMH Tier 3 practice recommendation, the PHP disenrolls the patient from the Pilots, AMH Tier 3 practices must close out any open referrals for Pilot services in NCCARE360, communicate directly with the HSO(s) regarding the change in status and ensure they do not submit invoices for further Pilot services, and update the patient's Care Plan. After a patient has been disenrolled from the Pilots, the AMH Tier 3 practice needs to communicate the decision to the patient and provide transition support by identifying non-Pilot services, programs and HSOs to meet the needs of the patient.

Use of NCCARE360 for Pilot Responsibilities

To participate in the Pilots, AMH Tier 3 practices—in addition to delegated CINs/Other Partners performing care management—must be registered and trained on NCCARE360 for core Pilot responsibilities including:

- Developing the member's record and profile in NCCARE360 if it does not already exist.
- Obtaining consent for sharing patients' personal data, including personal health information, with organizations in the NCCARE360 network.
- Completing the PESA documentation, transmitting it to the PHP for review, and reviewing PHP decisions on eligibility and service authorization.
- Generating referrals to HSOs for authorized Pilot services.
- Monitoring referrals to HSOs for authorized Pilot services to ensure they are accepted by the HSO and communicating with the HSO on patient progress as needed.

- Using the PESA to conduct the 3-month and 6-month assessment.
- Instructing HSOs to close out referrals for services that are no longer needed/authorized
- Prompting disenrollment from the Pilots if the patient is no longer eligible to participate.

Whichever entity is contracted by the PHP to provide care management must be registered, trained and actively use NCCARE360 to promote whole-person care.

Participation in Pilot Convenings/Trainings

Pilot-Related Convenings

The Healthy Opportunities Network Leads will hold regular telephonic or web-based convenings with Pilot-participating entities, including AMH Tier 3 practices serving as a Designated Pilot Care Management Entity, to share learnings and best practices as well as at least two in-person convenings per year that include all Pilot participating entities (HSOs, NLs, PHPs, etc.). Specifically, the Healthy Opportunities Network Leads convenings will:

- Solicit information about implementation barriers and best practices and identify areas where training and/or technical assistance would support effective Pilot implementation;
- Review Pilot-related policies and procedures; and
- Strengthen relationships between Pilot-participating entities.

The Department will also hold learning collaboratives designed to share best practices across Pilot regions.

AMH Tier 3 practices must participate in both the Healthy Opportunities Network Leads and the Department-led convenings; where applicable, the Healthy Opportunities Network Leads and the Department will specify the intended audiences for each convening so AMH Tier 3 practices can determine who from the practice is best suited to attend.

Training and Technical Assistance

The Healthy Opportunities Network Leads will provide training for care management entities, including AMH Tier 3 practices, on available Pilot services and appropriate contracted HSOs based on a patient's circumstances and care needs preferences. Training materials and forums may include webinars, written materials, and targeted, one-on-one training. The Department will also hold trainings for Pilot-participating AMH Tier 3 practices, CINs/Other Partners and their care managers to support successful Pilot implementation.

The Healthy Opportunities Network Leads will also provide ongoing technical assistance for AMH Tier 3 practices, to:

- Address issues related to Pilot services and HSO availability/accessibility;
- Support AMH Tier 3 practices ability to refer patients to contracted HSOs and adhere to Pilot responsibilities; and
- Support AMH Tier 3 practices' understanding of and familiarity with contracted HSOs and Plot services.

AMH Tier 3 practices must participate in both the Healthy Opportunities Network Leads and the Department-led trainings as well as the Healthy Opportunities Networks Leads technical assistance; where applicable, the

Healthy Opportunities Network Leads and the Department will specify the intended audiences for each training and technical assistance session so AMH Tier 3 practices can determine who from the practice is best suited to attend.

Supporting Pilot-Enrolled Patients Transitioning between Care Management Entities and/or PHPs

A patient's transition between service delivery systems, including between PHPs and care management entities can pose unique challenges to ensuring service continuity and coordination. AMH Tier 3 practices have robust existing requirements for supporting transitions of care for patients that are moving between PHPs and/or care management entities. **Building off the existing requirements for supporting transitions of care, AMH Tier 3 practices will be required to do the following for Pilot-enrolled patients:**

- **Coordinate a timely warm handoff, or a transfer of care between AMH Tier 3 practices and/or PHPs** for effective knowledge transfer or to ensure patient continuity of care with regards to Pilot services;
- **Promote proactive communication** regarding the patient's Pilot participation/services with the receiving entity (e.g., the PHP, a new AMH Tier 3 practice, etc.) prior to transition to coordinate the transfer of care;
- **Establish a follow-up protocol** to communicate with the receiving entity (e.g., the PHP, a new AMH Tier 3 practice, etc.) after the patient's transition to confirm receipt of the transferred information and to troubleshoot dynamics related to the Pilots that may have resulted from the transition;
- **Work with the HSO and former PHP** to ensure the continued delivery of any current Pilot services authorized while the member was still enrolled with the former PHP;
- **Use the NCCARE360 functionality** to send the new Designated Pilot Care Management Entity or PHP a summary of services using a Transition of Care Referral Request [See Transition of Care Policy for more detail].
- **For AMH Tier 3 practices acting as the receiving entity in a transition of care, ensure that members are reassessed** for ongoing Pilot eligibility and service mix within 90-days of transfer following a transition of care.
- **In the case that a referral for services has not yet been accepted by the HSO**, the AMH Tier 3 must close the case.
- **For services that were accepted by the HSO and not yet started**, the AMH Tier 3 must contact the HSO to close the case for the Pilot service.

Pilot-Related Member and Provider Issues and Complaints

Pilot services have been approved as part of the State's 1115 waiver and are separate from North Carolina's Medicaid managed care benefit package available statewide to Medicaid members. For this reason, Medicaid members are not entitled to receive Pilot services, and traditional Medicaid managed care "appeals and grievances" processes do not apply to adverse determinations made about Pilot services/eligibility. However, to keep the member at the center of the Pilot experience, AMH Tier 3 practices will support the tracking and resolution of Pilot-related issues and complaints submitted by members. AMH Tier 3 practices must submit any Pilot-related member issues/complaints to the PHP. Further, for any member issues/complaints that involve the AMH Tier 3 practice, AMHs will be required to resolve those issues in a timely manner.
In addition, AMH Tier 3 practices will be permitted to submit Pilot-related provider issues and complaints directly to the PHP.

Section IV: AMH Practice Eligibility Criteria to Participate in the Pilots for Pilot Participation

AMH Practice Eligibility Criteria to Participate in the Pilots

To participate in the Pilots, AMH practices must:

- **Be certified with the Department as an AMH Tier 3 practice,**
- **Be contracted with at least one PHP as a Tier 3 AMH, either directly or through their delegated CIN/Other Partner,**
- **Provide care management to Medicaid managed care-enrolled patients in a Pilot region, either directly or through their delegated CIN/Other Partner (note—AMHs may only provide Pilot-related care management for enrollees of PHPs for which it is contracted as a Tier 3), and**
- **Contract with the PHP to assume Pilot-related responsibilities using Department-standardized contracting terms and conditions**

If an AMH Tier 3 practice does not participate in the Pilots, there is no effect on their AMH Tier 3 status.

Section V: AMH Tier 3 Payment for Pilot Responsibilities

When Pilot service delivery begins in 2022, AMH Tier 3 practices that are contracted with one or more PHPs to provide Pilot care management services will receive Pilot care management payments from the PHPs. Pilot care management payments are not negotiated. Instead, DHHS will require PHPs to pay AMH Tier 3 practices serving as a Designated Pilot Care Management Entity (or their delegated CIN/Other Partner, if applicable based on chosen contracting arrangements) an additional, DHHS-standardized, Pilot Care Management per member per month (PMPM) payment, on top of existing care management and medical home payments. The PHP must pay AMH Tier 3 practices a Pilot Care Management per member per month (PMPM) payment for each Medicaid member assigned to a Pilot-participating AMH Tier 3 practice regardless of Pilot enrollment, on top of existing care management and medical home payments, initially, at Pilot launch. Pilot design seeks to maintain (and not disrupt) current contracting and payment practices. Given that each relationship between PHPs, AMH Tier 3 practices, and CINs is unique, entities are encouraged to continue their existing processes for Pilot care management payments. PHPs must use the care management rates and payment approach outlined in the Healthy Opportunities Pilots Payment Protocol to pay AMH Tier 3 practices for Pilot-related care management, and are not permitted to further negotiate rates. The Department reserves the right to modify this payment approach in the future, including to require that PHPs pay contracted AMH Tier 3 practices based on actual Pilot enrollment, rather than attributed population.

Section VI: PHP Oversight of AMH Tier 3 Practices for Pilot Responsibilities

PHPs will be responsible for overseeing and monitoring AMH Tier 3 compliance with Pilot responsibilities but may not put additional requirements on Designated Pilot Care Management Entities above and beyond what the Department requires

Under the existing AMH program, PHPs are responsible for overseeing and monitoring compliance of each contracted AMH Tier 3. PHPs are not permitted to hold AMH Tier 3 practices accountable for requirements that go above and beyond the AMH Tier 3 program requirements. PHPs are permitted to downgrade AMH Tier 3 practices if they determine that those practices are out of compliance with the AMH program requirements (discussed further below in Section VII: Changes in AMH Status and Pilot Participation), but PHPs must use a defined process for their “downgrade” actions.

PHPs also have the ability to put an individual AMH Tier 3 practice on a corrective action plan if the practice is found to have a pattern of making expedited referrals of patients that are subsequently found to be ineligible for the Pilots. The PHP will also have the ability to discontinue an individual AMH Tier 3 practice's ability to refer patients to pre-approved services if that practice continues to have a pattern of making expedited referrals for patients that are subsequently found to be ineligible for the Pilots. PHPs should give prior notification to AMH Tier 3 practices if they are outliers in referring ineligible members to the program and given a time period to demonstrate improvement.

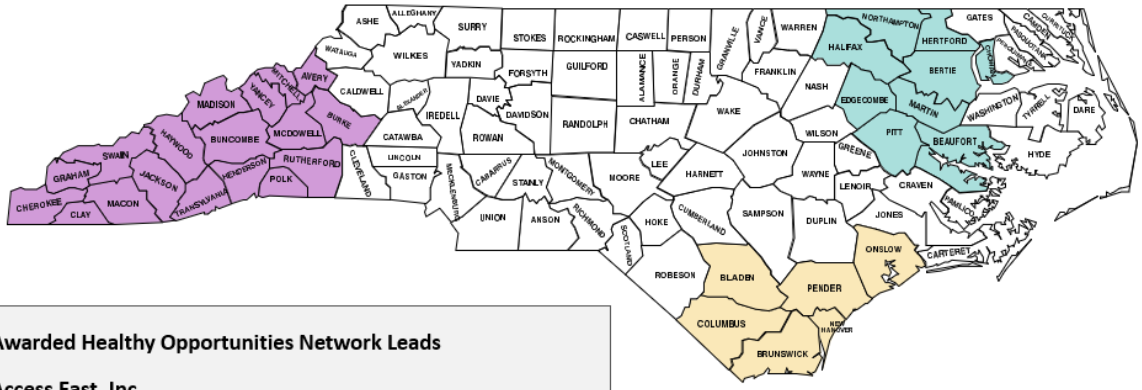
Section VII: Changes in AMH Status and Pilot Participation

To participate in the AMH program, practices must be certified as an AMH Tier 3 by the Department. Practices may confirm or change their AMH status on the NCTracks site. If a practice certified as an AMH Tier 3 determines that it needs additional time to meet Tier 3 requirements, it may change its Tier status without penalty. In addition, for AMH Tier 3 practices that are out of compliance with the activities associated with Tier 3 participation, a PHP may "downgrade" the practice, or move a practice out of the AMH program altogether. PHPs must allow AMH Tier 3 practices and CINs/Other Partners at least 30 days for remediation of non-compliance with Tier 3 standards before pursuing a tier downgrade.

If an AMH Tier 3 changes or loses its Tier 3 status with any PHP, it will also lose its Pilot certification and Pilot care management payment with the same PHP. If that AMH is contracted with other PHPs at the Tier 3 level, it can continue to participate in the Pilots with those PHPs unless they also downgrade the practice's Tier 3 status.

As discussed above in Section VI: PHP Oversight of AMH Tier 3 Practices for Pilot Responsibilities, **if a PHP determines that an AMH Tier 3 is not adequately meeting Pilot requirements, it may lose its Pilot certification and corresponding Pilot care management payment.**

Appendix G. Healthy Opportunities Pilots Guidance for AMH Tier 3 Practices



Awarded Healthy Opportunities Network Leads

Access East, Inc.

Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Dogwood Health Trust

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Appendix H. Healthy Opportunities Pilots Fee Schedule

Pilot Service Rates

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Housing		
Housing Navigation, Support and Sustaining Services	PMPM	$400.26
Inspection for Housing Safety and Quality	Cost-Based Reimbursement Up to A Cap	Up to $250 per inspection
Housing Move-In Support	Cost-Based Reimbursement Up to A Cap	• 1 BR: Up to $900 per month • 2 BR: Up to $1,050 per month • 3 BR: Up to $1,150 per month • 4 BR: Up to $1,200 per month • 5+ BR: Up to $1,250 per month
Essential Utility Set-Up	Cost-Based Reimbursement Up to A Cap	• Up to $500 for utility deposits • Up to $500 for reinstatement utility payment • Up to $500 for utility arrears
Home Remediation Services	Cost-Based Reimbursement Up to A Cap	Up to $5,000 per year[23]
Home Accessibility and Safety Modifications	Cost-Based Reimbursement Up to A Cap	Up to $10,000 per lifetime of waiver demonstration[24]
Healthy Home Goods	Cost-Based Reimbursement Up to A Cap	Up to $2,500 per year
One-Time Payment for Security Deposit and First Month's Rent	Cost-Based Reimbursement Up to A Cap	• First month's rent: Up to 110% FMR[25] (based on home size) • Security deposit: Up to 110% FMR (based on home size) x2
Short-Term Post Hospitalization Housing	Cost-Based Reimbursement Up to A Cap	• First month's rent: Up to 110% FMR (based on home size)

[23] The HSO that coordinates the contractors to deliver the Home Remediation Service will receive $125 per Home Remediation Service project that costs no more than $1,250 and will receive $250 per Home Remediation Service project that costs between $1,250 and $5,000.

[24] The HSO that coordinates the contractors to deliver the Home Accessibility and Safety Modification will receive $250 per Home Accessibility Modification project that costs no more than $2,500 and will receive $500 per Home Accessibility and Safety Modification project that costs between $2,500 and $10,000.

[25] Fair Market Rent (FMR) standards as established by the U.S. Department of Housing and Urban Development, available here: https://www.huduser.gov/portal/datasets/fmr.html#2022

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
		• Security deposit: Up to 110% FMR (based on home size) x2
Interpersonal Violence / Toxic Stress		
IPV Case Management Services	PMPM	$221.96
Violence Intervention Services	PMPM	$168.94
Evidence-Based Parenting Curriculum	One class	$22.60
Home Visiting Services	One home visit	$67.89
Dyadic Therapy	Per occurrence	$68.25
Food		
Food and Nutrition Access Case Management Services	15 minute interaction	$13.27
Evidence-Based Group Nutrition Class	One class	$22.80

Diabetes Prevention Program	• Four classes (first phase)
	• Three classes (second phase)[26]
		• **Phase 1: $275.83**
		  • Completion of 4 classes: $27.38
		  • Completion of 4 additional classes (8 total): $54.77
		  • Completion of 4 additional classes (12 total): $68.46
		  • Completion of 4 additional classes (16 total): $125.22
		• **Phase 2: $103.44**
		  • Completion of 3 classes: $31.02
		  • Completion of 3 additional classes (6 total): $72.42

Fruit and Vegetable Prescription	Cost-Based Reimbursement Up to A Cap	Up to $210 per month[27]
Healthy Food Box (For Pick-Up)	One food box	• Small box: $89.29 • Large box: $142.86
Healthy Food Box (Delivered)	One food box	• Small box: $96.79 • Large box: $150.36

[26] The Centers for Disease Control and Prevention recognized Diabetes Prevention Program is offered in two phases, including a minimum of 16 classes in Phase 1 and 6 classes in Phase 2. The DPP program is payed for in allocations so HSOs that participate in the Pilot are able to receive pro-rated payments as enrollees complete four classes.

[27] The HSO that coordinates the Fruit and Vegetable Prescription service will receive $5.25 per person served in a given month.

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Healthy Meal (For Pick-Up)	One meal	$7.00
Healthy Meal (Home Delivered)	One meal	$7.60
Medically Tailored Home Delivered Meal	One meal	$7.80
Transportation		
Reimbursement for Health-Related Public Transportation	Cost-Based Reimbursement Up to A Cap	Up to $102 per month
Reimbursement for Health-Related Private Transportation	Cost-Based Reimbursement Up to A Cap	Up to $267 per month[28]
Transportation PMPM Add-On for Case Management Services	PMPM	$71.30
Cross-Domain		
Holistic High Intensity Enhanced Case Management	PMPM	$501.41
Medical Respite	Per diem	$206.98
Linkages to Health-Related Legal Supports	15 minute interaction	$25.30

[28] Repairs to a Pilot Enrollee's car may be deemed an allowable, cost-effective alternative to private transportation by the Enrollee's Prepaid Health Plan. Reimbursement for this service may not exceed six months of capped private transportation services.

Housing Services

Housing Navigation, Support and Sustaining Services

Category	Information
Service Name	Housing Navigation, Support and Sustaining Services

Service Description	Provision of one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing (e.g., identifying housing preferences and developing a housing support plan), and to support an enrollee in maintaining stable, long-term housing (e.g., development of independent living skills, ongoing monitoring and updating of housing support plan). Activities may include:
	Housing Navigation and Support
	• Assisting the enrollee to identify housing preferences and needs.
	• Connecting the enrollee to social services to help with finding housing necessary to support meeting medical care needs.
	• Assisting the enrollee to select adequate housing and complete a housing application, including by:
	  ○ Obtaining necessary personal documentation required for housing applications or programs;
	  ○ Supporting with background checks and other required paperwork associated with a housing application
	• Assisting the enrollee to develop a housing support and crisis plan to support living independently in their own home.
	• Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan.
	• Assisting to complete reasonable accommodation requests.
	• Identifying vendor(s) for and coordinating housing inspection, housing move-in, remediation and accessibility services.
	• Assisting with budgeting and providing financial counseling for housing/living expenses (including coordination of payment for first month's rent and short-term post hospitalization rental payments).
	• Providing financial literacy education and on budget basics and locating community-based consumer credit counseling bureaus
	• Coordinating other Pilot housing-related services, including:
	  ○ Coordinating transportation for enrollees to housing-related services necessary to obtain housing (e.g. apartment/home visits).
	  ○ Coordinating the enrollee's move into stable housing including by assisting with the following:
	  ▪ Logistics of the move (e.g., arranging for moving company or truck rental);
	  ▪ Utility set-up and reinstatement;
	  ▪ Obtaining furniture/commodities to support stable housing
	  ○ Referral to legal support to address needs related to finding and maintaining stable housing.
	Tenancy Sustaining Services
	• Assisting the enrollee in revising housing support/crisis plan.

	• Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan, including assistance applying to related programs to ensure safe and stable housing (e.g., Social Security Income and weatherization programs), or assuring assistance is received from the enrollee's Medicaid care manager.
	• Assisting the enrollee with completing additional or new reasonable accommodation requests.
	• Supporting the enrollee in the development of independent living skills.
	• Connecting the enrollee to education/training on tenants' and landlords' role, rights and responsibilities.
	• Assisting the enrollee in reducing risk of eviction with conflict resolution skills.
	• Coordinating other Pilot housing-related services, including:
	  ○ Assisting the enrollee to complete annual or interim housing re-certifications.
	  ○ Coordinating transportation for enrollees to housing-related services necessary to sustain housing.
	  ○ Referral to legal support to address needs related to finding and maintaining stable housing.
	
	Activities listed above may occur without the Pilot enrollee present. For homeless enrollees, all services must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.
	
	The HSO has the option to partner with other organizations to ensure it is able to provide all activities described as part of this service. If desired by the HSO, the Lead Pilot Entity can facilitate partnerships of this kind.

Frequency *(if applicable)*	As needed
Duration *(if applicable)*	On average, individuals require 6-18 months of case management services to become stably housed but individual needs will vary and may continue beyond the 18 month timeframe. Service duration would persist until services are no longer needed, as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	• The majority of sessions with enrollees should be in-person, in a setting desired by the individual. In-person meetings will, on average occur for the first 3 months of service. • Case managers may only utilize telephonic contacts if appropriate. • Some sessions may be "off-site," (e.g., at potential housing locations).
Minimum Eligibility Criteria	• Enrollee is assessed to be currently experiencing homelessness, are at risk of homelessness and those whose quality/safety of housing are adversely affecting their health. Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.

	• Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollees may not simultaneously receive the Housing Navigation, Support and Sustaining Services and the IPV Case Management Services. Individuals with co-occurring housing and IPV-related needs should receive the Holistic High Intensity Case Management service. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Inspection for Housing Safety and Quality

Category	Information
Service Name	Inspection for Housing Safety and Quality

Service Description	A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Inspections may assess the habitability and/or environmental safety of an enrollee's current or future dwelling. Inspections may include:
	• Inspection of building interior and living spaces for the following:
	  ○ Adequate space for individual/family moving in;
	  ○ Suitable indoor air quality and ventilation;
	  ○ Adequate and safe water supply;
	  ○ Sanitary facilities, including kitchen, bathroom and living spaces
	  ○ Adequate electricity and thermal environment (e.g. window condition) and absence of electrical hazards;
	  ○ Potential lead exposure;
	  ○ Conditions that may affect health (e.g. presence of chemical irritants, dust, mold, pests);
	  ○ Conditions that may affect safety.
	• Inspection of building exterior and neighborhood for the following:
	  ○ Suitable neighborhood safety and building security;
	  ○ Condition of building foundation and exterior, including building accessibility; and,
	  ○ Condition of equipment for heating, cooling/ventilation and plumbing.
	
	Inspector must communicate inspection findings to the care or case manager working with the enrollee to ensure referrals to appropriate organizations for additional home remediation and/or modifications, if necessary.
	
	This service can cover Housing Quality Standards (HQS) inspections upon move-in to a new residence, or other inspections to identify sub-standard housing that impacts an enrollee's health and safety.
	
	This service covers failed inspections and re-inspections.

	Each housing inspection does not need to include all activities listed in this service description. Service providers should only execute the necessary components of a housing safety and quality inspection as required based on an enrollee's circumstances. Costs for services provided must be commensurate with a vendor's scope of activities.
Frequency *(if applicable)*	• Enrollees may receive ad hoc assessments to identify housing quality, accessibility and safety issues at time of indication as needed when that current housing may be adversely affecting health or safety. • Housing Quality Standards (HQS) inspections must occur at enrollee move-in to new place of residence if enrollee will receive "One-Time Payment for Security Deposit" and First Month's Rent or "Short Term Post Hospitalization Housing" services.
Duration *(if applicable)*	Approximately one hour.
Setting	Housing inspection should occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Inspections may be conducted for individuals who are moving into new housing units (e.g., HQS Inspection) or for individuals who are currently in housing that may be adversely affecting their health or safety. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Housing Move-In Support

Category	**Information**
Service Name	Housing Move-In Support

Service Description	Housing move-in support services are non-recurring set-up expenses. Allowable expenses include but are not limited to the following:
	• Moving expenses required to occupy and utilize the housing (e.g., moving service to transport an individual's belongings from current location to new housing/apartment unit, delivery of furniture, etc.)
	• Discrete goods to support an enrollee's transition to stable housing as part of this service. These may include, for example:
	  ○ Essential furnishings (e.g., mattresses and beds, dressers, dining table and chairs);
	  ○ Bedding (e.g., sheets, pillowcases and pillows);
	  ○ Basic kitchen utensils and dishes;
	  ○ Bathroom supplies (e.g., shower curtains and towels);
	  ○ Cribs;
	  ○ Cleaning supplies.

	This service shall not cover used mattresses, cloth, upholstered furniture, or other used goods that may pose a health risk to enrollees.
Frequency *(if applicable)*	Enrollees that meet minimum service eligibility criteria may receive housing move-in support services when they move into a housing/apartment unit for the first time or move from their current place of residence to a new place of residence. This service may be utilized more than once per year, so long as overall spending remains below the annual cap.
Duration *(if applicable)*	N/A
Setting	Variable. Many housing move-in support services will occur in the enrollee's current place of residence or potential residence. Some discrete goods may be given to an enrollee in a location outside the home, including an HSO site or clinical setting.

Minimum Eligibility Criteria	• Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management.
	  ○ Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan.
	• Housing move-in support services are available for individuals who are moving into housing from homelessness[29] or shelter, or for individuals who are moving from their current housing to a new place of residence due to one or more of the reasons listed under "Minimum Eligibility Criteria."
	• Enrollee is moving into housing/apartment unit due to one or more of the following reasons:
	  ○ Transitioning from homelessness or shelter to stable housing;

[29] The Healthy Opportunities Pilots define homelessness by the U.S. Department of Health and Human Services (HHS) definition from Section 330 of the Public Health Service Act (42 U.S.C., 254b) and HRSA/Bureau of Primary Health Care Program Assistance Letter 88-12, Health Care for the Homeless Principles of Practice, available at: https://www.nhchc.org/faq/official-definition-homelessness/.

	○ Addressing the sequelae of an abusive relationship ○ Evicted or at risk of eviction from current housing; ○ Current housing is deemed unhealthy, unsafe or uninhabitable by a certified inspector; ○ Displaced from prior residence due to occurrence of a natural disaster. • This Pilot service is furnished only to the extent that the enrollee is unable to meet such expense or when the services cannot be reasonably obtained from other sources. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Essential Utility Set-Up

Category	**Information**
Service Name	Essential Utility Set-Up
Service Description	The Essential Utility Set Up service is a non-recurring payment to: • Provide non-refundable, utility set-up costs for utilities essential for habitable housing. • Resolve arrears related to unpaid utility bills and cover non-refundable utility set-up costs to restart the service if it has been discontinued in a Pilot enrollee's home, putting the individual at risk of homelessness or otherwise adversely impacting their health (e.g., in cases when medication must be stored in a refrigerator). This service may be used in association with essential home utilities that have been discontinued (e.g., initial payments to activate heating, electricity, water, and gas).
Frequency *(if applicable)*	Enrollees may receive this service at any point at which they meet service minimum eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	• An enrollee's home • Utility vendor's office
Minimum Eligibility Criteria	• Enrollee must require service either when moving into a new residence or because essential home utilities have been discontinued or were never activated at move-in and will adversely impact occupants' health if not restored. • Enrollee demonstrates a reasonable plan, created in coordination with care manager or case manager, to cover future, ongoing payments for utilities. • This Pilot service is furnished only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.

	• This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Home Remediation Services

Category	Information
Service Name	Home Remediation Services
Service Description	Evidence-based home remediation services are coordinated and furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home remediation services may include for example pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens, or lead abatement.
Frequency *(if applicable)*	Enrollees may receive home remediation services at any point at which they meet minimum service eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	Home remediation services occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. ○ The housing unit may be owned by the enrollee (so long as it is their primary place of residence) or rented. • Landlord has agreed to and provided signed consent for approved home remediation services prior to service delivery (if applicable). • Landlord has agreed to and provided signed consent to keep rent at current rate for a period of twenty-four months after receiving Pilot Home remediation services prior to service delivery (if applicable). • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Home Accessibility and Safety Modifications

Category	Information
Service Name	Home Accessibility and Safety Modifications
Service Description	Evidence-based home accessibility and safety modifications are coordinated and furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home accessibility modifications are adjustments to homes that need to be made in order to allow for enrollee mobility, enable independent and safe living and accommodate medical equipment and supplies. Home modifications should improve the accessibility and safety of housing (e.g., installation of entrance ramps, hand-held shower controls, non-

	slip surfaces, grab bars in bathtubs, installation of locks and/or other security measures, and reparation of cracks in floor).
Frequency *(if applicable)*	Enrollees may receive home accessibility modifications at any point at which they meet minimum eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	Home accessibility and safety services will occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. ○ The housing unit may be owned by the enrollee (so long as it is their primary place of residence) or rented. • Landlord has agreed to and provided signed consent for approved home accessibility or safety modifications prior to service delivery (if applicable). • Landlord has agreed to and provided signed consent to keep rent at current rate for a period of twenty-four months after approved home accessibility or safety modification prior to service delivery (if applicable). • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Home Goods

Category	**Information**
Service Name	Healthy Home Goods
Service Description	Healthy-related home goods are furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home-related goods that may be covered include, for example, discrete items related to reducing environmental triggers in the home (e.g., a "Breathe Easy at Home Kit" with EPA-vacuum, air filter, green cleaning supplies, hypoallergenic mattress or pillow covers and non-toxic pest control supplies). Healthy Home Goods do not alter the physical structure of an enrollee's housing unit.
Frequency *(if applicable)*	Enrollees may receive healthy home goods when there are health or safety issues adversely affecting their health or safety.
Duration *(if applicable)*	N/A

Setting	Variable. Many times, goods will be given to an enrollee inside the home. Some goods (e.g., air filters) may be given to an enrollee in a location outside the home, including an HSO site or a clinical setting.
Minimum Eligibility Criteria	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

One-Time Payment for Security Deposit and First Month's Rent

Category	Information
Service Name	One-Time Payment for Security Deposit and First Month's Rent
Service Description	Provision of a one-time payment for an enrollee's security deposit and first month's rent to secure affordable and safe housing that meet's the enrollee's needs. All units that enrollees move into through this Pilot service must: • Pass a Housing Quality Standards (HQS) inspection • Meet fair market rent and reasonableness check • Meet a debarment check For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.
Frequency *(if applicable)*	Once per enrollee over the lifetime of the demonstration
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. ○ Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Enrollee must receive assistance with developing a reasonable plan to address future ability to pay rent through a housing stability plan. • Housing unit must pass a Housing Quality Standards (HQS) inspection prior to move-in or, in certain circumstances, a habitability inspection performed by the

	case manager or other staff. If a habitability inspection is performed, an HQS inspection must be scheduled immediately following move-in. • Landlord must be willing to enter into a lease agreement that maintains a satisfactory dwelling for the enrollee throughout the duration of the lease, unless there are appropriate and fair grounds for eviction. • This pilot service is provided only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Short-Term Post Hospitalization Housing

Category	Information
Service Name	Short-Term Post Hospitalization Housing
Service Description	Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness at discharge from inpatient hospitalization. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to housing in a private or shared housing unit. Short-Term Post Hospitalization Housing setting should promote independent living and transition to a permanent housing solution. Services may not be provided in a congregate setting, as defined by the Department. Allowable units for short-term post-hospitalization housing must provide the following for enrollees: • Access to a clean, healthy environment that allows enrollees to perform activities of daily living; • Access to a private or semi-private, independent room with a personal bed for the entire day; • Ability to receive onsite or easily accessible medical and case management services, as needed. Coordination of this service should begin prior to hospital discharge by a medical professional or AMH Tier 3 practice. The referral to Short-Term Post Hospitalization Housing should come from a member of the individual's care team. For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	Up to six months, contingent on determination of continued Pilot eligibility

Setting	Coordination should begin prior to hospital discharge. Services may not be provided in a congregate setting.
Minimum Eligibility Criteria	• Enrollee must receive Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management in tandem with this service. ○ Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Enrollee is imminently homeless post-inpatient hospitalization. • Enrollee must receive assistance with developing a reasonable plan to address future ability to pay rent through a housing stability plan. • Housing unit must pass a Housing Quality Standards (HQS) inspection prior to move-in or, in certain circumstances, a habitability inspection performed by the case manager or other staff. If a habitability inspection is performed, an HQS inspection must be scheduled immediately following move-in. • Landlord must be willing to enter into a lease agreement that maintains a satisfactory dwelling for the enrollee throughout the duration of the lease, unless there are appropriate and fair grounds for eviction. • This Pilot service is provided only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Interpersonal Violence / Toxic Stress Services

IPV Case Management Services

Category	Information
Service Name	IPV Case Management Services
Service Description	This service covers a set of activities that aim to support an individual in addressing sequelae of an abusive relationship. These activities may include: • Ongoing safety planning/management • Assistance with transition-related needs, including activities such as obtaining a new phone number, updating mailing addresses, school arrangements to minimize disruption of school schedule • Linkages to child care and after-school programs and community engagement activities

	• Linkages to community-based social service and mental health agencies with IPV experience, including trauma-informed mental health services for family members affected by domestic violence, including witnessing domestic violence • Referral to legal support to address needs such as obtaining orders of protection, negotiating child custody agreements, or removing legal barriers to obtaining new housing (excluding legal representation) • Referral to and provision of domestic violence shelter or emergency shelter, if safe and appropriate permanent housing is not immediately available, or, in lieu of shelter, activities to ensure safety in own home • Coordination with a housing service provider if additional expertise is required • Coordination of transportation for the enrollee that is necessary to meet the goals of the IPV Case Management service • Informal or peer counseling and advocacy related to enrollees' needs and concerns. These may include accompanying the recipient to appointments, providing support during periods of anxiety or emotional distress, or encouraging constructive parenting activities and self-care. Activities listed above may occur without the Pilot enrollee present. The HSO has the option to partner with other organizations to ensure it is able to provide all activities described as part of this service. If desired by the HSO, the Lead Pilot Entity can facilitate partnerships of this kind.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	Various settings are appropriate, including at a shelter, home of the enrollee or home of friend or relative, supportive housing, clinical or hospital setting, enrollee's residence, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Enrollee requires ongoing engagement.[30] • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollees may not simultaneously receive the Housing Navigation, Support and Sustaining Services and the IPV Case Management Services. Individuals with co-occurring housing and IPV-related needs should receive the Holistic High Intensity Case Management service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

[30] This service is not intended for single or highly intermittent cases often handled through crisis hotlines. The pre-authorized three month interval is designed to address the unpredictable needs and engagement level for those with a sustained relationship with a human services organization.

Violence Intervention Services

Category	Information
Service Name	Violence Intervention Services
Service Description	This service covers the delivery of services to support individuals who are at risk for being involved in community violence (i.e., violence that does not occur in a family context). Individuals may be identified based on being the victim of a previous act of crime, membership in a group of peers who are at risk, or based on other criteria. Once identified, Peer Support Specialists and case managers provide: • Individualized psychosocial education related to de-escalation skills and alternative approaches to conflict resolution • Linkages to housing, food, education, employment opportunities, and after-school programs and community engagement activities. Peer Support Specialists are expected to conduct regular outreach to their mentees, to maintain situational awareness of their mentees' milieu, and to travel to conflict scenes where their mentees may be involved in order to provide in-person de-escalation support. Activities listed above may occur without the Pilot enrollee present. The service should be informed by an evidence-based program such as (but not limited to) Cure Violence.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	Various settings are appropriate, including at an individual's home, school, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Individual must have experienced violent injury or be determined as at risk for experiencing significant violence by a case manager or by violence intervention prevention program staff members (with case manager concurrence) • Individual must be community-dwelling (i.e., not incarcerated). • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Evidence-Based Parenting Curriculum

Note: North Carolina has priced one approved curriculum, and will finalize a full list of allowable curricula and associated prices after selection of Pilot regions.

Category	Information
Service Name	Evidence-Based Parenting Classes
Service Description	Evidence-based parenting curricula are meant to provide: • Group and one-on-one instruction from a trained facilitator • Written and audiovisual materials to support learning • Additional services to promote attendance and focus during classes Evidence-based parenting classes are offered to families that may be at risk of disruption due to parental stress or difficulty coping with parenting challenges, or child behavioral or health issues. These services are also appropriate for newly reunited families following foster care/out of home placement or parental incarceration. This service description outlines one approved curriculum: Incredible Years (Parent) – Preschool/School. This service should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	18-20 sessions, typically lasting 2-2.5 hours each.
Setting	Services may be provided in a classroom setting or may involve limited visits to recipients' homes.
Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Home Visiting Services

Note: North Carolina has priced one approved curriculum, and will finalize a full list of allowable curricula and associated prices after selection of Pilot regions.

Category	Information
Service Name	Home Visiting Services
Service Description	Home Visiting services are meant to provide: • One-one observation, instruction and support from a trained case manager who may be a licensed clinician • Written and/or audiovisual materials to support learning Evidence-based home visiting services are offered to families that may be at risk of disruption due to parental stress or difficulty coping with parenting challenges, or child behavioral or health issues. These services are also appropriate for newly reunited

	families following foster care/out of home placement or parental incarceration. This service description outlines one approved curriculum: Parents As Teachers. This service should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	• Families with one or no high-needs characteristics should get at least 12 home visits annually • Families with two or more high-needs characteristics should receive at least 24 home visits annually • Home visits last approximately 60 minutes • Home visits provided beyond 6 months are is contingent on determination of continued Pilot eligibility
Setting	Various settings are appropriate, including at an individual's home, school, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Dyadic Therapy Services

Category	**Information**
Service Name	Dyadic Therapy Services
Service Description	This service covers the delivery of dyadic therapy to benefit a child/adolescent at risk for or with an attachment disorder, a behavioral or conduct disorder, a mood disorder, an obsessive-compulsive disorder, post-traumatic stress disorder, or as a diagnostic tool to assess for the presence of these disorders. This service only covers therapy provided to the parent or caregiver of a Pilot enrolled child to address the parent's or caregiver's behavioral health challenges that are negatively contributing to the child's well-being. This is not a group-based therapy. Sessions are limited to the parent(s) or caregiver(s) of the child/adolescent. Treatments are based on evidence-based therapeutic principles (for example, trauma-focused cognitive-behavioral therapy). When appropriate, the Pilot enrolled child should but is not required to receive Medicaid-covered behavioral health or dyadic therapy services as a complement to this Pilot service. This service aims to support families in addressing the sequelae of adverse childhood experiences and toxic stress that may contribute to adverse health outcomes.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	As needed, contingent on determination of continued Pilot eligibility

Setting	Services may be delivered in a range of locations, including but not limited to at a provider's location or in the recipient's home.
Minimum Eligibility Criteria	• The covered individual is 21 years old or younger • The parent or caregiver recipient of this service cannot be eligible to receive this service as a Medicaid covered service. • The covered individual is at risk for or has a disorder listed above that can be addressed through dyadic therapy directed at the covered individual's parent or caregiver, delivered together or separately, that is not otherwise covered under Medicaid. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded program.

Food Services

Food and Nutrition Access Case Management Services

Category	Information
Service Name	Food and Nutrition Access Case Management Services

Service Description	Provision of one-on-one case management and/or educational services to assist an enrollee in addressing food insecurity. Activities may include:
	• Assisting an individual in accessing school meals or summer lunch programs, including but not limited to:
	  ○ Helping to identify programs for which the individual is eligible
	  ○ Helping to fill out and track applications
	  ○ Working with child's school guidance counselor or other staff to arrange services
	• Assisting an individual in accessing other community-based food and nutrition resources, such as food pantries, farmers market voucher programs, cooking classes, Child and Adult Care Food programs, or other, including but not limited to:
	  ○ Helping to identify resources that are accessible and appropriate for the individual
	  ○ Accompanying individual to community sites to ensure resources are accessed
	• Advising enrollee on transportation-related barriers to accessing community food resources
	
	It is the Department's expectation that Medicaid care managers will assist all eligible individuals to enroll in SNAP and WIC and secure their enrollment through existing SNAP and WIC assistance resources. Food and Nutrition Access Case Managers will address more complex and specialized needs. However, if under exceptional circumstances a Food and Nutrition Access Case Manager identifies an individual for whom all other forms of assistance have been ineffective, they are permitted to assist the individual with

	completing enrollment, including activities such as addressing documentation challenges or contacting staff at a local SNAP or WIC agency to resolve issues, or otherwise.
Frequency *(if applicable)*	Ad hoc sessions as needed. It is estimated that on average individuals will not receive more than two to three sessions with a case manager.
Duration *(if applicable)*	N/A

Setting	• May be offered:
	  ○ At a community setting (e.g. community center, health care clinic, Federally Qualified Health Center (FQHC), food pantry, food bank)
	  ○ At an enrollee's home (for home-bound individuals)
	  ○ Via telephone or other modes of direct communication

Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Evidence-Based Group Nutrition Class

Category	**Information**
Service Name	Evidence-Based Group Nutrition Class
Service Description	This service covers the provision of an evidence-based or evidence-informed nutrition related course to a group of individuals. The purpose of the course is to provide hands-on, interactive lessons to enrollees, on topics including but not limited to: • Increasing fruit and vegetable consumption • Preparing healthy, balanced meals • Growing food in a garden • Stretching food dollars and maximizing food resources Facilitators may choose from evidence-based curricula, such as: • Cooking Matters (for Kids, Teens, Adults)[31] • A Taste of African Heritage (for Kids, Adults) [32] For curricula not outlined above, an organization must follow an evidence-based curricula that is approved by DHHS, in consultation with the Lead Pilot Entity and PHPs.
Frequency *(if applicable)*	Typically weekly
Duration *(if applicable)*	Typically six weeks

[31] More information on Cooking Matters available at: http://cookingmatters.org/node/2215

[32] More information on A Taste Of African Heritage available at: https://oldwayspt.org/programs/african-heritage-health/atoah-community-cooking-classes

Setting	Classes may be offered in a variety of community settings, including but not limited to health clinics, schools, YMCAs, Head Start centers, community gardens, or community kitchens.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Diabetes Prevention Program

Category	Information
Service Name	Diabetes Prevention Program
Service Description	Provision of the CDC-recognized "Diabetes Prevention Program" (DPP), which is a healthy living course delivered to a group of individuals by a trained lifestyle coach designed to prevent or delay type 2 diabetes. The program focuses on healthy eating and physical activity for those with prediabetes. The program must comply with CDC Diabetes Prevention Program Standards and Operating Procedures.[33]
Frequency *(if applicable)*	Minimum of 16 sessions in Phase I; Minimum of 6 sessions in Phase II, according to CDC Standards and Operating Procedures.
Duration *(if applicable)*	Typically one year, contingent on determination of continued Pilot eligibility
Setting	Intervention is offered at a community setting, clinical setting, or online, as part of the approved DPP curriculum.
Minimum Eligibility Criteria	• Enrollee must: ○ Be 18 years of age or older, ○ Have a BMI ≥ 25 (≥23 if Asian), ○ Not be pregnant at the time of enrollment ○ Not have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment, ○ Have one of the following: ▪ A blood test result in the prediabetes range within the past year, or ▪ A previous clinical diagnosis of gestational diabetes, or, ▪ A screening result of high risk for type 2 diabetes through the "Prediabetes Risk Test"[34]

[33] CDC Diabetes Prevention Program Standards and Operating Procedures, available at: https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf

[34] Available at: https://www.cdc.gov/prediabetes/takethetest/

	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Fruit and Vegetable Prescription

Category	Information
Service Name	Fruit and Vegetable Prescription
Service Description	Food voucher to be used by an enrollee with a diet or nutrition-related chronic illness to purchase fruits and vegetables from a participating food retailer. Participating food retailers must sell an adequate supply of WIC-eligible fruits and vegetables (i.e., fresh, frozen, canned without any added fats, salt, or sugar). Food retailers may include but are not limited to: • Grocery stores • Farmers markets • Mobile markets • Community-supported agriculture (CSA) programs • Corner stores A voucher transaction may be facilitated manually or electronically, depending on the most appropriate method for a given food retail setting. The cost associated with coordinating the provision of services are included.
Frequency *(if applicable)*	One voucher per enrollee. Each voucher will have a duration as defined by the HSO providing it. For example, some HSOs may offer a monthly voucher while others may offer a weekly voucher.
Duration *(if applicable)*	6 months (on average), contingent on determination of continued Pilot eligibility
Setting	Enrollees spend vouchers at food retailers. Human service organizations administer and coordinate the service in a variety of settings: engaging with enrollees in the community (e.g. health care and community-based settings) to explain the service, administering food retailer reimbursements and other administrative functions from their office, and potentially meeting with food retailers in the field.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high-risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.

	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Food Box (For Pick-Up)

Category	Information
Service Name	Healthy Food Box (For Pick-Up)
Service Description	A healthy food box for pick-up consists of an assortment of nutritious foods provided to an enrollee in a community setting, aimed at promoting improved nutrition for the service recipient. It is designed to supplement the daily food needs for food-insecure individuals with diet or nutrition-related chronic illness. This service does not constitute a full nutritional regimen (three meals per day per person). Healthy food boxes should be furnished using a client choice model when possible and should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions.
Frequency *(if applicable)*	Typically weekly
Duration *(if applicable)*	On average, this service is delivered for 3 months. Service would continue until services are no longer needed as indicated in an individual's person-centered care plan.
Setting	• Food is sourced and warehoused by a central food bank, and then delivered to community settings by the food bank. • Food is offered for pick-up by the enrollee in a community setting, for example at a food pantry, community center, or a health clinic.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high-risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Food Box (Delivered)

Category	Information
Service Name	Healthy Food Box (Home Delivered)
Service Description	A healthy food box for delivery consists of an assortment of nutritious foods that is delivered to an enrollee's home, aimed at promoting improved nutrition for the service recipient. It is designed to supplement the daily food needs for food-insecure individuals with diet or nutrition-related chronic illness. This service does not constitute a full nutritional regimen (three meals per day per person). Healthy food boxes should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions.
Frequency *(if applicable)*	Typically weekly
Duration *(if applicable)*	On average, this service is delivered for 3 months. Service would continue until services are no longer needed as indicated in an individual's person-centered care plan.
Setting	• Food is sourced and warehoused by a central food bank. • Food boxes are delivered to enrollee's home.
Minimum Eligibility Criteria	• Enrollee does not have capacity to shop for self or get to food distribution site or have adequate social support to meet these needs. • Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high-risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.

Healthy Meal (For Pick-Up)

Category	Information
Service Name	Healthy Meal (For Pick-Up)
Service Description	A healthy meal for pick-up consists of a frozen or shelf stable meal that is provided to an enrollee in a community setting, aimed at promoting improved nutrition for the service recipient. This service includes preparation and dissemination of the meal. Meals must provide at least one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National

	Academy of Sciences,[35] and adhere to the current Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.[36] Meals may be tailored to meet cultural preferences and specific medical needs. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Frequency of meal services will differ based on the severity of the individual's needs.
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	• Meals are offered for pick-up in a community setting, for example at a food pantry, community center, or a health clinic.
Minimum Eligibility Criteria	• Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs. • Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Meal (Home Delivered)

Category	Information
Service Name	Healthy Meal (Home Delivered)
Service Description	A healthy, home-delivered meal consists of a hot, cold, or frozen meal that is delivered to an enrollee's home, aimed at promoting improved nutrition for the service recipient. This service includes preparation and delivery of the meal. Meals must provide at least one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences,[37] and adhere to the current Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the

[35] Dietary Reference Intakes available at: https://www.nal.usda.gov/fnic/dietary-reference-intakes.
[36] Most recent version of the Dietary Guidelines for Americans is available at: https://health.gov/dietaryguidelines/2015/guidelines/.
[37] Dietary Reference Intakes available at: https://www.nal.usda.gov/fnic/dietary-reference-intakes.

	U.S. Department of Agriculture.[38] Meals may be tailored to meet cultural preferences and specific medical needs. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Meal delivery services for enrollees requiring this service will differ based on the severity of the individual's needs. On average, individuals receive 2 meals per day (or 14 meals per week).
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	Meals are delivered to enrollee's home.
Minimum Eligibility Criteria	• Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs. • Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Medically Tailored Home Delivered Meal

Category	Information
Service Name	Medically Tailored Home Delivered Meal
Service Description	Home delivered meal which is medically tailored for a specific disease or condition. This service includes an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically-appropriate nutrition care plan, the preparation and delivery of the prescribed nutrition care regimen, and regular reassessment at least once every 3 months. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[39] Meals may be tailored to meet cultural preferences. For health conditions not outlined in the Food Is

[38] Most recent version of the Dietary Guidelines for Americans is available at: https://health.gov/dietaryguidelines/2015/guidelines/.

[39] FIMC standards available at: https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/5ca66566e5e5f01ac91a9ab4/1554408806530/FIMC+Nutriton+Standards-Final.pdf.

	Medicine Coalition standards above, an organization must follow a widely recognized nutrition guideline approved by the LPE. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Meal delivery services for enrollees requiring this service will differ based on the severity of the individual's needs. On average, individuals receive 2 meals per day (or 14 meals per week).
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	• Nutrition assessment is conducted in person, in a clinic environment, the enrollee's home, or telephonically as appropriate. • Meals are delivered to enrollee's home.

Minimum Eligibility Criteria	• Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs.
	• Eligible disease states include but are not limited to obesity, failure to thrive, slowed/faltering growth pattern, gestational diabetes, pre-eclampsia, HIV/AIDS, kidney disease, diabetes/pre-diabetes, and heart failure.
	• If potentially eligible for SNAP and/or WIC, the enrollee must either:
	  ○ Be enrolled in SNAP and/or WIC, or
	  ○ Have submitted a SNAP and/or WIC application within the last 2 months, or
	  ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months
	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.
	• Enrollee is not currently receiving duplicative support through other Pilot services.
	• This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service.
	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Transportation Services

Reimbursement for Health-Related Public Transportation

Category	Information
Service Name	Reimbursement for Health-Related Public Transportation
Service Description	Provision of health-related transportation for qualifying Pilot enrollees through vouchers for public transportation. This service may be furnished to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being. The service may include transportation to locations indicated in an enrollee's care plan that may include, for example: • Grocery stores/farmer's markets; • Job interview(s) and/or place of work;

	• Places for recreation related to health and wellness (e.g., public parks and/or gyms); • Group parenting classes/childcare locations; • Health and wellness-related educational events; • Places of worship, services and other meetings for community support; • Locations where other approved Pilot services are delivered. Pilot transportation services will not replace non-emergency medical transportation as required in Medicaid.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Family, neighbors and friends are unable to assist with transportation • Public transportation is available in the enrollee's community. • Service is only available for enrollees who do not have access to their own or a family vehicle. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Reimbursement for Health-Related Private Transportation

Category	Information
Service Name	Reimbursement for Health-Related Private Transportation
Service Description	Provision of private health-related transportation for qualifying Pilot enrollees through one or more of the following services: • Community transportation options (e.g., local organization that organizes and provides transportation on a volunteer or paid basis) • Direct transportation by a professional, private or semi-private transportation vendor (e.g., shuttle bus company or privately operated wheelchair-accessible transport)[40] • Account credits for taxis or ridesharing mobile applications for transportation Private transportation services may be utilized in areas where public transportation is not an available and/or not an efficient option (e.g., in rural areas).

[40] An organization providing non-emergency medical transportation in North Carolina is permitted to provide this Pilot service. However, the organization will only receive reimbursement when an individual is transported in accordance with the Pilot service requirements, including that the service is furnished to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being.

	The following services may be deemed allowable, cost-effective alternatives to private transportation by a Pilot enrollee's Prepaid Health Plan (PHP):[41] • Repairs to an enrollee's vehicle • Reimbursement for gas mileage, in accordance with North Carolina's Non-Emergency Medical Transportation clinical policy[42] This service may be furnished to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being. The service may include transportation to locations indicated in an enrollee's care plan that may include, for example: • Grocery stores/farmer's markets; • Job interview(s) and/or place of work; • Places for recreation related to health and wellness (e.g. public parks and/or gyms); • Group parenting classes/childcare locations; • Health and wellness-related educational events; • Places of worship, services and other meetings for community support; • Locations where other approved Pilot services are delivered. Pilot transportation services will not replace non-emergency medical transportation as required in Medicaid.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

[41] Repairs to a enrollee's vehicle and reimbursement for gas mileage may be particularly likely to be cost-effective alternatives in rural areas of North Carolina but may also applicable in other areas of the State with limited public transportation.

[42] Reimbursement for gas mileage must be in accordance with North Carolina's Non-Emergency Medical Transportation (NEMT) Policy, available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NC/NC-18-011.pdf.

Transportation PMPM Add-On for Case Management Services

Category	Information
Service Name	Transportation PMPM Add-On for Case Management Services
Service Description	Reimbursement for coordination and provision of transportation for Pilot enrollees provided by an organization delivering one or more of the following case management services: • Housing Navigation, Support and Sustaining Services • IPV Case Management • Holistic High Intensity Enhanced Case Management This service is for transportation needed to meet the goals of each of the case management services listed above. Transportation must be to and from appointments related to identified case management goals. For example, an organization providing Housing Navigation, Support and Sustaining Services may transport an individual to potential housing sites. An organization providing IPV case management may transport an individual to peer support groups and sessions. Transportation will be managed or directly provided by a case manager or other HSO staff member. Allowable forms of transportation include, for example: • Use of HSO-owned vehicle or contracted transportation vendor; • Use of personal car by HSO case manager or other staff member; • Vouchers for public transportation; • Account credits for taxis/ridesharing mobile applications for transportation (in areas without access to public transportation. Organizations that provide case management may elect to either receive this PMPM add-on to cover their costs of providing and managing enrollees' transportation, or may use the "Reimbursement for Health-Related Transportation" services—public or private—to receive reimbursement for costs related to enrollees' transportation (e.g., paying for an enrollee's bus voucher). Organizations will have the opportunity to opt in or out of the PMPM add-on annually. Organizations that have opted in for the PMPM add-on may not separately bill for "Reimbursement for Health-Related Transportation" services.

Cross-Domain Services

Holistic High Intensity Enhanced Case Management

Category	Information
Service Name	Holistic High Intensity Enhanced Case Management
Service Description	Provision of one-to-one case management and/or educational services to address co-occurring needs related to housing insecurity and interpersonal violence/toxic stress, and as needed transportation and food insecurities. Activities may include those outlined in the following three service definitions: • Housing Navigation, Support and Sustaining Services • Food and Nutrition Access Case Management Services • IPV Case Management Services

	Note that case management related to transportation needs are included in the services referenced above. Activities listed above may occur without the Pilot enrollee present. The HSO has the option to partner with other organizations to ensure it is able to provide all activities described as part of this service. If desired by the HSO, the Lead Pilot Entity can facilitate partnerships of this kind.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	• Most sessions with enrollees should be in-person, in a setting desired by the individual. In-person meetings will, on average occur for the first 3 months of service. • Case managers may only utilize telephonic contacts if deemed appropriate. • Some sessions may be "off-site," (e.g., at potential housing locations).
Minimum Eligibility Criteria	• Enrollee must concurrently require both Housing Navigation, Support and Sustaining Services and IPV Case Management services. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Medical Respite

Category	**Information**
Service Name	Medical Respite Care
Service Description	A short-term, specialized program focused on individuals who are homeless or imminently homeless, have recently been discharged from a hospital setting and require continuous access to medical care. Medical respite services include comprehensive residential care that provides the enrollee the opportunity to rest in a stable setting while enabling access to hospital, medical, and social services that assist in completing their recuperation. Medical respite provides a stable setting and certain services for individuals who are too ill or frail to recover from a physical illness/injury while living in a place not suitable for human habitation, but are not ill enough to be in a hospital. Medical respite services should include, at a minimum: **Short-Term Post-Hospitalization Housing:** Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness at discharge. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to housing in a private or shared housing unit. Short-Term Post Hospitalization Housing setting should promote independent living and

	transition to a permanent housing solution. Services may not be provided in a congregate setting, as defined by the Department. Allowable units for short-term post-hospitalization housing must provide the following for enrollees: • Access to a clean, healthy environment that allows enrollees to perform activities of daily living; • Access to a private or semi-private, independent room with a personal bed for the entire day; • Ability to receive onsite or easily accessible medical and case management services, as needed. Coordination of this service should begin prior to hospital discharge by a medical professional or team member. The referral to medical respite should come from a member of the individual's care team. For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness. **Medically Tailored Meal *(delivered to residential setting)*** Home delivered meal which is medically tailored for a specific disease or condition. This service includes an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically-appropriate nutrition care plan, as well as the preparation and delivery of the prescribed nutrition care regimen. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[43] Meals may be tailored to meet cultural preferences. For health conditions not outlined in the Food Is Medicine Coalition standards above, an organization must follow a widely recognized nutrition guideline approved by the LPE. This service does not constitute a full nutritional regimen (three meals per day per person). **Transportation Services** Provision of private/semi-private transportation services, reimbursement for public transportation and reimbursement for private transportation (e.g., taxis and ridesharing apps—only in areas where public transportation is unavailable) for the enrollee receiving medical respite care to social services that promote community engagement, health and well-being. *Refer to service definitions for Reimbursement for Health-Related Public*

[43] FIMC Standards available at: https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/5ca66566e5e5f01ac91a9ab4/1554408806530/FIMC+Nutriton+Standards-Final.pdf.

	Transportation and Reimbursement for Health-Related Private Transportation for further service description detail. Medical respite program staff are required to check-in regularly with the individual's Medicaid care manager to coordinate physical, behavioral and social needs.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	Up to six months, contingent on determination of continued Pilot eligibility.
Setting	• The majority of the services will occur in the allowable short-term post-hospitalization housing settings described in the service description. • Some services will occur outside of the residential setting (e.g., transportation to wellness-related activities/events, site visits to potential housing options).
Minimum Eligibility Criteria	• Individuals who are homeless or imminently homeless, have recently been discharged from a hospital setting and require continuous access to medical care. • Enrollee should remain in Medical Respite only as long as it is indicated as necessary by a healthcare professional. • Enrollee requires access to comprehensive medical care post-hospitalization • Enrollee requires intensive, in-person case management to recuperate and heal post-hospitalization. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Linkages to Health-Related Legal Supports

Category	**Information**
Service Name	Linkages to Health-Related Legal Supports
Service Description	This service will assist enrollees with a specific matter with legal implications that influences their ability to secure and/or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress. This service may cover, for example: • Assessing an enrollee to identify legal issues that, if addressed, could help to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress, including by reviewing information such as specific facts, documents (e.g., leases, notices, and letters), laws, and programmatic rules relevant to an enrollee's current or potential legal problem; • Helping enrollees understand their legal rights related to maintaining healthy and safe housing and mitigating or eliminating exposure to interpersonal violence or toxic stress (e.g., explaining rights related to landlord/tenant disputes, explaining the purpose of an order of protection and the process for obtaining one);

	• Identifying potential legal options, resources, tools and strategies that may help an enrollee to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress (e.g., providing self-advocacy instructions, removing a former partner's debts from credit rating); • Providing advice to enrollees about relevant laws and course(s) of action and, as appropriate, helping an enrollee prepare "pro se" (without counsel) documents. This service is meant to address the needs of an individual who requires legal expertise, as opposed to the more general support that can be offered by a care manager, case manager or peer advocate. The care manager or case manager coordinating this service must clearly identify the scope of the authorized health-related legal support within the enrollee's care plan. This service is limited to providing advice and counsel to enrollees and does not include "legal representation," such as making contact with or negotiating with an enrollee's potential adverse party (e.g., landlord, abuser, creditor, or employer) or representing an enrollee in litigation, administrative proceedings, or alternative dispute proceedings. After issues are identified and potential strategies reviewed with an enrollee, the service provider is expected to connect the enrollee to an organization or individual that can provide legal representation and/or additional legal support with non-Pilot resources.
Frequency *(if applicable)*	As needed when minimum eligibility criteria are met
Duration *(if applicable)*	Services are provided in short sessions that generally total no more than 10 hours.
Setting	Various settings are appropriate. Services described above may be provided via telephone or other modes of direct communication (with or without the Pilot enrollee present) or in person, as appropriate, including, for example, the home of the enrollee, another HSO site, or other places convenient to the enrollee.
Minimum Eligibility Criteria	• Service does not cover legal representation. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • The enrollee's Medicaid care manager or HSO case manager is responsible for clearly defining the scope of the authorized health-related legal support services. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Appendix I. Healthy Opportunities Pilots Standard Terms and Conditions

Healthy Opportunities Pilots Standard Terms and Conditions for PHP Contracts with AMH Tier 3 Practices Serving as a Designated Pilot Care Management Entity

1. Background

The Advanced Medical Home (AMH) program refers to an initiative under which the PHP delegates care management responsibilities and functions to State-designated AMH practices either directly or through the practices clinically integrated network (CIN) or other partner to provide local care management services. Refer to Section III.C.6. Care Management for additional detail regarding the AMH Program. An AMH "practice" will be defined by a NPI and service location.

2. Scope

The scope of this Policy covers the agreement between the PHP, the clinically integrated network (if applicable) and primary care providers participating in the AMH program outlined below and in the Contract.

The scope of the terms below covers the agreement between the PHP and AMH Tier 3 Practices serving as a Designated Pilot Care Management Entity.[44] As this is a pilot program, the Department will continually review and update entity requirements based on the on the ground experience of Designated Pilot Care Management Entity. Unless otherwise specified, any required element may be performed either by the AMH Tier 3 practice itself or by a clinically integrated network (CIN) or other partner with which the practice has a contractual agreement that contains equivalent contract requirements. PHPs should align with contracting for current AMH care management for standard plan members. Contracting can follow current arrangements in situations where AMH providers use their CIN to negotiate or contract on their behalf. The PHP shall pay AMH Tier 3 practices or their delegated entity serving as a Designated Pilot Care Management Entity an additional, DHHS-standardized, Pilot Care Management per member per month (PMPM) payment for each Medicaid member assigned to a Pilot-participating AMH Tier 3 regardless of Pilot enrollment, on top of existing care management and medical home payments, initially, at Pilot launch on February 1, 2022. PHPs must use the care management rates and payment approach outlined in the Healthy Opportunities Pilots Payment Protocol to pay AMH Tier 3 practices for Pilot-related care management, and are not permitted to further negotiate rates. The Department reserves the right to modify this payment approach in the future, including to require that PHPs pay contracted AMH Tier 3 practices based on actual Pilot enrollment, rather than attributed population.

Standard Terms and Conditions for PHP Contracts with AMH Tier 3 Providers or CINs Participating in the Healthy Opportunities Pilots. The AMH Tier 3 practice must:

General

- Conduct all Pilot-related responsibilities detailed in the Pilot Participation section of the AMH Tier 3 Provider Manual.
- Be onboarded onto and utilize NCCARE360 for all Pilot-related functionalities. The Department will cover the cost of NCCARE360 use for Medicaid members for functionality required by the Department.
- Follow any future DHHS-developed guidance documents or protocols related to the provision of Pilot-related care management.

[44] A Designated Care Management Entity that is assuming care management responsibilities specifically related to the Healthy Opportunities Pilot.

- The PHP is not permitted to add any additional oversight, monitoring or reporting requirements above and beyond what is enumerated in these terms and conditions.

Identify Potentially Pilot-Eligible Members

- Assess potentially Pilot-eligible Members currently receiving care management for baseline Pilot program eligibility, including qualifying physical/behavioral qualifying criteria and social risk factor(s) (see Appendix in the AMH Provider Manual for eligibility criteria).
- Undertake best efforts to conduct outreach to the Member in a timely manner, and in accordance of the Provider Manual upon receipt of a referral of a potentially Pilot-eligible member.
- Utilize social determinants of health (SDOH) screenings, Comprehensive Assessments, other evidence-based assessment tools, and findings from regular care management check-ins with members to identify Pilot-eligible individuals.
- Build in opportunities for assessing Members' Pilot eligibility at additional checkpoints with the member at existing check-ins (e.g., transitions of care).

Assess Pilot Eligibility and Recommend Pilot Services

- Assess potentially Pilot-eligible members referred to the AMH Tier 3 for Pilot eligibility assessment from external sources (e.g., the PHP) and members assigned to the AMH Tier 3 that are currently receiving care management, for qualifying criteria and recommend specific Pilot services.
- Use the Pilot Eligibility and Service Assessment (PESA) to document standardized information regarding Pilot eligibility and recommended services (see AMH Provider Manual Section on Pilot Participation)
- Complete the PESA for the initial Pilot eligibility assessment/service recommendations and anytime there is a change to a Members' Pilot service needs or eligibility.
- Utilize NCCARE360 to transmit the enrollment and authorization request to the member's PHP for service authorization.

Obtain Pilot Consent

- Obtain or verify all required consents from the member in an electronic or written format prior to the member being enrolled in the Pilot and receiving Pilot services.

Refer to and Confirm Delivery of Pilot Services

- Conduct outreach to the member about authorized Pilot services.
- Include in the Member's care plan information on Pilot enrollment status, authorized Pilot services and Pilot-related needs.
- Upon Pilot enrollment, initiate care management to the member if the member is not already receiving care management. Continue providing care management if the member is already receiving it.
    - Ensure that care management is delivered in accordance with AMH Program requirements, as detailed in the AMH Provider Manual.
- Make referrals for authorized Pilot services using NCCARE360 upon receiving PHP authorization.
    - PHPs will monitor receipt of invoices from Health Service Organizations (HSOs) to ensure that referrals are occurring and services are being delivered in a timely manner.
- Follow-up with the HSO (if the referral is not accepted) and elevate the issue to the appropriate Network Lead as required.
    - Network Leads will ~~over see~~oversee HSO network performance across their Pilot region.

- PHPs are not required to monitor HSO referral acceptance as HSO performance is predominately a Network Lead function.
- Once an HSO begins providing a Pilot service to a Pilot enrollee:
    - Track the status of a referral to an HSO to ensure that Pilot service delivery is initiated.
    - Coordinate with the HSO that accepted the referral in order to track the outcomes of authorized Pilot service(s) and to ensure Pilot service(s) are meeting the enrollee's needs, as needed.
    - Update the Pilot service delivery outcome(s) in the Pilot section of a member's care plan.

Expedite Referral to Pre-Approved Services

- Identify potentially-Pilot eligible members that are currently in care management or who have been referred to the AMH for a Pilot assessment, who would benefit from one of the pre-approved services [See Appendix of AMH Provider Manual for Approved Pilot Services].
- Upon identification of a member that would benefit from a pre-approved service, and once required consents are obtained, send the PESA to PHP recommending an additional duration of the service beyond the 30-day pass-through period, indicating that the member is provisionally enrolled in Pilot and pre-authorized to receive a Pilot service for passthrough period of 30-days.
- Upon identification of a member that would benefit from a pre-approved service, refer the member to an HSO that delivers Pilot service for a passthrough period of 30-days, simultaneously with the transmittal of the PESA to the PHP.
- If the member is deemed eligible by the PHP for additional Pilot services beyond the 30-day passthrough period:
    - Generate a referral to the same HSO to deliver the remaining Pilot services past the initial 30-days.
    - Engage with the member to inform them that they are authorized to receive the full duration of the Pilot service.
- If the member is deemed ineligible by the PHP for additional Pilot services beyond the 30-day passthrough period:
    - Do not issue another referral for the remaining Pilot services past the initial 30 days.
    - Engage with the member to inform them and direct them to other non-Pilot services to meet their needs.

Reassess Pilot Service Mix Review and Eligibility

- Conduct a Pilot service mix review every 3 months and reassess Pilot eligibility every 6 months and update the status of the assessment within the member's PESA in NCCARE360 using the notes field.
- Identify Pilot enrollees requiring 3-month and 6-month reassessments and schedule and conduct the service mix review and/or eligibility reassessment in a manner that is aligned with the guidance provided in the AMH Provider Manual on Pilot responsibilities.
- PHPs will review data collected in NCCARE360 to monitor requirements for Pilot service mix reviews and eligibility reassessment through spot audits of member PESAs, but will not require additional reporting of AMH Tier 3 practices. In the future, the Department expects that NCCARE360 will have a monitoring dashboard that can be utilized for this functionality.

Transitions to Another PHP or Designated Pilot Care Management Entity

- If a member moves to another PHP while enrolled in the Pilot, the AMH Tier 3 practice must:

- Use the NCCARE360 functionality to send the PHP a summary of services using a Transition of Care Referral Request [See Transition of Care Policy for more detail.]
- In the case that a referral for services has not yet been accepted by the HSO, the AMH Tier 3 must close the case.
- For services that were accepted by the HSO and not yet started, the AMH Tier 3 must contact the HSO to close the case for the Pilot service.

- If a member moves to another Designated Pilot Care Management Entity, the AMH Tier 3 practice must:
  - Coordinate a timely warm handoff, or a transfer of care between AMH Tier 3 practices for effective knowledge transfer or to ensure patient continuity of care with regards to Pilot services
  - Use the NCCARE360 functionality to send the new Designated Care Management Entity a summary of services using a Transition of Care Referral Request [See Transition of Care Policy for more detail.]

Discontinuation of Pilot Services

- If an AMH Tier 3 practice identifies a Pilot service to be discontinued, it must:
  - Document the service(s) to be discontinued and rationale (e.g., if the service is no longer meeting the member's need) and notifies the PHP via NCCARE360.
  - Close out any open referrals for the discontinued service(s) in NCCARE360 and communicates with HSO regarding enrollee status.
  - Document discontinued service(s) and rationale for discontinuation in the Member's PESA within NCCARE360 and the member's care plan.
  - Communicate with the member and provide transition support by identifying other Pilot and non-Pilot services and programs to meet ongoing needs.

Disenrollment from the Pilots

- Identify the following circumstances that result in Pilot-disenrollment:
  - The enrollee is no longer enrolled in Medicaid managed care;
  - The enrollee has moved out of a Pilot region; or
  - The enrollee is receiving duplicative services/programs that disqualify them from the Pilots (e.g., individuals in intermediate care facilities for individuals with intellectual disabilities).
  - The enrollee have not been responsive for more than 6 months and have not responded to requests for the 3 month service mix review and the 6 month eligibility assessment.
- Document information and rationale for Pilot disenrollment in the PESA and transmit it to the PHP for verification.
- Upon receipt of the disenrollment decision:
  - Communicate with the member regarding the change(s) to Pilot services.
  - Close out any open referrals for the discontinued service(s) in NCCARE360 and communicate with HSO(s).
  - Document PHP decision on Pilot disenrollment in the member's care plan.
  - Provide transition support by identifying non-Pilot services and programs to meet the needs of the member.

Member and Provider Issues and Complaints

- If an AMH Tier 3 has any issues or complaints related to the Pilot, it may transmit those issues directly to the PHP.

- If the AMH Tier 3 is made aware of any Pilot-related member-related issues and complaints, it will transmit them directly to the PHP.
- Address member-related complaints routed by the PHP in a timely manner, and document the action taken using standard member issue/complaint documentation policies for non-Pilot issues